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	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Rehabilitation Health Center	1735 Adkins Street Eugene, OR 97401

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review it was determined the facility failed to determine the appropriateness for the self-administration of medication for 4 of 9 sampled residents (#s 5, 10 12, 68, and 108) reviewed for accidents and nutrition. This placed residents at risk for an ineffective medication regimen. Findings include:1. Resident 5 was admitted to the facility in 3/2024 with a diagnosis of heart failure. Resident 5's 3/11/24 Self-Administration of Medication form revealed she/he was capable but did not want to self-administer medications. Resident 5's Order Details form revealed Salonpas was to be administered PRN left knee pain. The order indicated the medication could be kept at Resident 5's bedside. Resident 5's 12/17/25 Quarterly MDS revealed she/he had moderate cognitive and memory problems. Resident 5's clinical record revealed there was no assessment to ensure she/he was safe to administer Salonpas. On 1/28/26 at 10:50 AM Staff 4 (LPN) stated a resident could have medications at the bedside after an assessment was completed. Staff 4 stated Resident 5 had orders to keep the medication at the bedside. On 1/28/26 at 10:57 AM Staff 3 (RNCM) stated If a resident was to have medications at the bedside there needed to be a physician order, the medication was to be kept in a secure location, and a self-medication assessment was to be completed before allowing medications at the bedside. Staff 3 stated Resident 5 was not assessed to ensure she/he was able to self-administer medications. On 2/2/26 at 10:08 AM Staff 2 (DNS) stated if a resident had medications at the bedside, a resident was to be assessed to ensure she/e was capable of self-administration, the medication was to be in a secure location, and orders were to be obtained. 2. Resident 10 was admitted to facility in 6/2018 with diagnoses including calcific tendinitis of left shoulder (a painful condition caused by calcium deposit buildup within the rotator cuff tendons) and pneumonia. The quarterly MDS with an ARD of 10/31/25, revealed Resident 10 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment, and experienced occasional severe pain. Observations on 1/26/26 at 3:35 PM and 1/27/26 at 3:28 PM revealed Resident 10 had lidocaine cream on her/his nightstand and a bottle of 3% hydrogen peroxide first aid antiseptic spray on her/his (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shelf. Resident 10 stated she/he had the lidocaine cream and antiseptic for a few months. On 1/27/26 at 3:28 PM, Resident 10 applied lidocaine cream onto her/his left neck, shoulder and wrist. Resident 10 also demonstrated the use of the first aid antiseptic by holding the spray to her/his mouth. Resident 10 stated she/he sprayed the antiseptic into her/his mouth before rinsing it out with mouthwash. A review of Resident 10's clinical record revealed no self-administration of medication assessment was completed to determine the resident's ability to safely self-administer topical lidocaine or first aid antiseptic spray. On 1/28/26 at 11:46 AM, Staff 11 (CNA) stated she was not aware of Resident 10 having medications in her/his room or if Resident 10 had been authorized to have medications at her/his bedside. On 1/29/25 at 8:38 AM, Staff 12 (CNA) stated she was not aware of Resident 10's ability to self-administer medications or if Resident 10 had been authorized to have medications at her/his bedside. Staff 12 stated if medications were found by a resident's bedside, she would inform the nurse. On 1/29/26 at 8:52 AM, Staff 13 (CMA) stated Resident 10 was known to purchase a variety of her/his own medications and keep the medications in her/his room. Staff 13 stated she has taken medications from Resident 10's room in the past and reported the incident to the nurse. Staff 13 stated there was a process for residents to self-administer their own medications. On 1/29/26 at 9:20 AM, Staff 7 (LPN) stated he was not aware of Resident 10 having authorization to self-administer medications. Staff 7 stated as of 1/28/26 at 1:32 PM, an order was received for Resident 10 to have lidocaine cream at her/his bedside. Staff 7 stated there was no order for Resident 10 to use antiseptic in her/his mouth. On 1/30/26 at 3:02 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they expected an evaluation and orders to be in place for residents to self-administer medications. 3. The facility's 3/2023 Right to Self-Administer Medication outlined the following criteria for a resident to self-administer medications: 1. If a resident has requested to self-administer medications, it is the responsibility of the interdisciplinary team to determine it is safe before the resident exercise the right. A resident may self-administer medications after the interdisciplinary team has determined which medications be self-administered. 2. Considerations in determining of the resident is clinically appropriate to self-administer include: a. Which medications are appropriate and safe for self-administration. b. The resident physical capacity to swallow without difficulty and to open medication packaging. c. The resident's cognitive status, including ability to correctly identify medications and know for which conditions s/he is taking medication. 3. Appropriate documentation of the determinations will be documented in the resident's medical (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record and care plan. Resident 12 was admitted to the facility in 4/2025 with diagnosis including acute respiratory failure and chronic obstructive pulmonary disease. A review of Resident 12's 10/30/25 Quarterly MDS revealed she/he was cognitively intact. On 1/27/26 at 2:41 PM a Breyna inhaler (also known as Symbicort, a combination of budesonide and formoterol fumarate, a corticosteroid and long-acting agonist) and Albuterol Sulfate inhaler (a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs) was observed on Resident 12's bedside table. Resident 12 stated the blue inhaler (Breyna) was her/his medicine which her/he took one or two times a day and the green (albuterol) inhaler was her/his rescue inhaler and she/he used when needed. A review of Resident 12's 1/2026 MAR indicated the resident was approved by her/his provider to keep Symbicort and Albuterol Sulfate at bedside. An 8/15/25 Self-Administration of Medication assessment revealed Resident 13 was evaluated for wanting to self-administer medication, the list of medications approved to self-administer, and location of storage was not assessed. On 1/28/26 at 3:59 PM Staff 26 (LPN) stated Resident 12 did not have any inhalers at bedside and she/he was not capable of accessing the nightstand drawer to lock/unlock to get the medications. On 1/28/26 at 4:07 PM Staff 25 (CMA) stated Resident 12 had one inhaler (Symbicort) at bedside and would use it twice a day. On 1/30/26 at 9:30 AM Staff 4 (LPN) stated Resident 12 had one inhaler (Albuterol Sulfate) at bedside and would use it as needed. On 1/30/26 at 11:03 AM Staff 3 (RN, Unit Manager) stated she was aware Resident 12 had Symbicort inhaler at bedside and was not aware the resident had Albuterol Sulfate or did not have a lockbox. Staff 3 stated she expected any residents who had medications at their bedside to have a completed self-administration assessment which includes the names of the medications and a lock box for the medication. On 1/30/26 at 2:10 PM Staff 2 (DNS) stated she expected staff to be aware of all residents who are allowed to have medications at bedside, the specific medications, and have the medications secured in a lockbox. 4. Resident 68 was admitted to the facility 7/2023 with a diagnosis of Alzheimer's disease. The quarterly MDS with an ARD of 1/3/26, revealed Resident 68 had a BIMS score of 8, which indicated the resident had moderate cognitive impairment. Observations on 1/27/26 at 11:57 AM and 1/28/26 at 4:05 PM revealed Resident 68 had a tube of Ammonium Lactate cream by her/his bedside and two tubes in her/his shelf. Resident 68's name and instructions were observed on the prescription label. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/26 at 4:04 PM, Resident 68 stated staff did not assist with applying the cream to her/his feet. Resident 68 stated the cream was for the gangrene on her/his feet. On 1/28/26 at 4:05 PM, Resident 68 could not explain the quantity or frequency of the cream's use and stated staff did not assist her/him with the application. A review of Resident 68's clinical record revealed no self-administration of medication assessment was completed to determine the resident's ability to safely self-administer ammonium lactate cream to her/his feet. On 1/29/26 at 8:49 AM, Staff 10 (CNA) stated she was not aware of Resident 68 having medications at her/his bedside. She stated if she saw medications at Resident 68's bedside, she would let the nurse know. On 1/29/26 at 8:52 AM, Staff 13 (CMA) stated she was not aware of Resident 68 having the ability to self-administer medications. Staff 13 stated there was a process for residents to self-administer their own medications. On 1/29/26 at 9:40 AM, Staff 7 (LPN) acknowledged the ammonium lactate cream by Resident 68's bedside and shelf. Staff 7 stated he was not sure what the cream was for and confirmed it was not on Resident 68's orders, and the resident did not have skin issues on her/his feet. On 1/30/26 at 3:02 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they expected an evaluation and orders to be in place for residents to self-administer medications. 5. Resident 108 was admitted to facility 6/2023 with diagnoses including muscle weakness and chronic pain. The quarterly MDS with an ARD of 12/1/25, revealed Resident 108 had a BIMS score of 15, which indicated the resident was cognitively intact. Observations on 1/26/26 at 1:21 PM revealed Resident 108 had antifungal powder, Aspercreme, and Icy Hot on her/his shelf. Resident 108 stated she/he sometimes used the products on her/himself. Observations on 1/27/26 at 3:39 PM revealed Resident 108 had antifungal powder at her/his bedside and the Apsercreme on her/his shelf. A review of Resident 108's clinical record revealed no self-administration of medication assessment was completed to determine the resident's ability to safely self-administer Aspercreme, antifungal powder, or Icy Hot. On 1/29/26 at 8:41 AM, Staff 10 (CNA) stated she was not aware of Resident 108's ability to self-administer medications. On 1/29/26 at 9:00 AM, Staff 7 (LPN) stated Resident 108 and her/his family were known to purchase over-the-counter medications and bring them to her/his room. On 1/29/26 at 9:34 AM, Staff 7 confirmed there was no order for Resident 108 to self-administer medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/26 at 3:02 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they expected an evaluation and orders to be in place for residents to self-administer medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review it was determined the facility failed to ensure food temperatures were maintained and to provide palatable food from 1 of 1 facility kitchen and 3 of 5 sampled residents (#s 11, 29 and 57) reviewed for food. This placed residents at risk for food that was not palatable, safe, or appetizing. Findings include: 1.Resident 11 was admitted to the facility in 1/26 with diagnoses including anemia (low red blood cell count) and kidney failure. The 1/18/26 admission MDS revealed a BIMS assessment revealed a score of 15 for Resident 11. On 1/26/26 at 9:41 AM, Resident 11 was observed with her/his breakfast in her/his room. Resident 11 stated the food was not warm and she/he refused to eat it. Staff 32 (CNA) entered the room and Resident 11 stated her/his eggs, toast, and oatmeal were cold. Staff 32 did not offer to address her/his cold food. On 1/26/26 at 12:36 PM, meal trays were loaded on a cart from the dining room and taken to Resident 11's hall. On 1/29/26 at 10:49 AM, Resident 11 stated her/his meals were often cold. Resident 11 stated she/he would ask for an alternative, but staff did not return with warm food. Resident 11 stated the food was always cold; therefore, she/he had family bring snacks to the facility. Resident 11 stated she/he informs the staff daily the food is cold, but nothing changes regarding her/his breakfast of scrambled eggs, toast, and oatmeal. On 1/29/26 12:37 PM, Staff 23 (CNA) stated the residents complain frequently about cold food. Staff 23 stated it was difficult to warm all the trays for the residents and still perform work duties. Staff 23 stated management needed to ensure the residents had hot meals. Staff 23 stated staff do the best they can to get meal trays out, but it does not take long for the food to become cold. On 1/30/26 at 12:10 PM, Staff 2 (DNS) and Staff 22 (Regional Dining Director) acknowledged the facility was aware of cold food complaints by residents. Staff 2 and Staff 22 stated sufficient food delivery equipment was required to address the cold food concerns. 2. Resident 29 was admitted to the facility in 12/2025 with diagnosis including heart disease. A 12/13/25 Care Plan indicated Resident 29 required staff to assist with the set-up of her/his meals. The 12/19/25 admission MDS revealed a BIMS assessment score of 14 (cognitively intact) for Resident 29. On 1/26/26 at 12:36 PM, meal trays were loaded on a cart from the dining room and taken to Resident 29's hall. On 1/26/26 at 12:41 PM, Resident 29 was observed with her/his meal in her/his room and stated the food was not warm. An unidentified CNA in the resident's room did not offer to address her/his cold food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/26 at 10:49 AM, Resident 29 stated her/his meals were often late and cold and reheated food took too long to be returned. On 1/28/26 at 1:23 PM, Resident 29 was observed in her/his room with a lunch tray and napkin on her/his plate. Resident 29 stated she completed her/his meal and acknowledged her/his meal was half eaten. Resident 29 stated her/his lunch arrived 10 minutes earlier and her/his potato arrived cold and could not melt butter. Resident 29 stated the meal was late and she/he expected food to arrive around noon. On 1/30/26 at 9:01 AM, Staff 27 (CNA) stated residents frequently complained about cold food when served in the residents' rooms and food was often cold from the beginning of service. Staff 27 stated meals were late two to three times each week and there was no effective method to reheat residents' food. Staff 27 stated any lack of staffing impacted the ability for meals to be delivered timely. On 1/30/26 at 12:10 PM, Staff 22 (Regional Dining Director) acknowledged the facility was aware of cold food complaints by residents and sufficient food delivery equipment was required to address the cold food concerns. 3. Resident 57 was admitted to the facility in 4/2025 for muscle wasting and diabetes. The 1/25/26 Quarterly MDS revealed a BIMS score of 14 (cognitively intact) for Resident 57. Resident 57 was on a CCD (controlled carbohydrate diet) regular texture diet. On 1/29/26 at 12:40 PM several lunch meals were observed to be plated without metal warming plates and loaded on to the cart. On 1/29/26 at 12:43 PM the lunch cart was sent out from the kitchen to Sequoia Hall. On 1/29/26 at 1:04 PM Staff 35 (CNA) delivered Resident 57's lunch tray to her/his room. Resident 57 ordered a three-ounce pork chop, Italian pasta salad, tossed salad with dressing and dinner roll. Resident 57 received one pork chop on the plate and tossed salad. The resident stated there was no food warmer under the plate and the pork chop did not feel warm. Resident 57 stated food is often served cold. On 1/29/26 at 1:08 PM Staff 35 stated she went to the kitchen to request the missing items for Resident 57. Staff 35 stated the dietary staff stated the Italian pasta salad and dinner roll had run out. Staff 35 stated residents frequently complained about cold food served in the residents' rooms and the kitchen running out of food. On 1/30/26 at 1:19 PM Staff 1 (Administrator) acknowledged Sequoia Hall had complaints of cold food complaints and food running out.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review it was determined the facility failed to ensure residents were informed of the risks and benefits of psychotropic medications for 1 of 5 sampled residents (#13) reviewed for unnecessary medications. This placed residents at risk for being uninformed about their medications. Findings include: Resident 13 was admitted to the facility in 7/2025 with diagnoses including right femur fracture and visual hallucinations. Resident 13's 1/2026 Physician Orders indicated the resident was prescribed risperidone for dementia with behaviors ordered on 8/18/25 and trazodone for insomnia ordered on 11/17/25.Resident 13's consent for risperidone was verbally obtained on 9/26/25 and no consent was found for trazadone.A review of Resident 13's 1/2026 MAR revealed the resident received risperidone twice a day and trazadone daily in the evening. On 1/30/26 at 2:10 PM Staff 2 (DNS) acknowledged Resident 13 was not informed of the risks and benefits of the use of risperidone and trazodone prior to use.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to have a process in place to ensure resident rights to execute an advance directive, provide follow up and obtain copies for the medical record for 3 of 4 sampled residents (#s 10, 30, 108) reviewed for advance directives. Findings include: The facility's policy and guidelines for Advance Directives dated 3/2023 included the following:- If the resident has not formulated an advance directive, the facility will determine if the resident wishes to formulate an advance directive and provide assistance to the resident in the development of advance directives in accordance with state law. Documentation in the medical record will reflect the discussion of advance directives occurred, that assistance has been offered to the resident, and the resident's acceptance or declination of assistance. - The facility will periodically review the advance directives with the resident and/or the resident's representative. 1. Resident 10 was admitted to facility in 6/2018 with diagnoses including calcific tendinitis of left shoulder (a painful condition caused by calcium deposit buildup within the rotator cuff tendons) and pneumonia. The quarterly MDS with an ARD of 10/31/25, revealed Resident 10 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. On 1/27/26 at 3:28 PM, Resident 10 stated she/he had an advance directive, and staff did not discuss the details of her/his advance directives with her/him. A review of Resident 10's clinical record revealed on 6/19/18 she/he indicated having an advance directive, but the copy was not on file and there were no subsequent notes to indicate any attempts at obtaining the document. On 1/29/26 at 2:58 PM, Staff 8 (SSD) stated he expected a copy of a resident's advance directive to be on file when a resident indicated to have one. Staff 8 confirmed Resident 10 indicated to have an advance directive, but it was not on file. On 1/30/26 at 3:02 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated it was expected for staff to obtain a copy of a resident's advance directive if the resident indicated to have one. 2. Resident 30 was admitted to the facility in 9/2025 with a diagnosis including heart failure. A 12/17/25 signed Advance Directive Resident Information form revealed Resident 30 had an advance directive. The 1/10/25 revised Care Plan indicated Resident 30 did not have an advance directive. On 1/29/26 at 4:13 PM, Staff 9 (Director of Social Services) acknowledged Resident 30 did have an advance directive and there was no copy on file. Staff 9 stated the resident's care plan was not revised to reflect accurate information about her/his advance directive and a copy of her/his advance directive was not obtained within a week as expected. 3. Resident 108 was admitted to facility 6/2023 with diagnoses including muscle weakness and chronic pain. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS with an ARD of 12/1/25, revealed Resident 108 had a BIMS score of 15, which indicated the resident was cognitively intact. On 1/27/26 at 11:40 AM, Resident 108 stated the facility had not talked to her/him about an advance directive and she/he did not know what an advance directive was. On 1/30/26 at 2:58 PM, Staff 8 (SSD) stated if a resident did not have an advance directive, he expected staff to follow up and educate and offer information to the resident every quarter. Staff 8 confirmed Resident 108 did not have an advance directive and confirmed there were no notes to indicate she/he was educated and offered one. On 1/30/26 at 3:02 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated it was expected for staff to educate, offer and assist residents with an advance directive when residents indicate to not have one.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview it was determined the facility failed to ensure residents' health information was kept private for 2 of 2 sampled residents (#s 82 and 105). This placed residents at risk for lack of privacy. Findings include: 1. On 1/26/26 at 10:44 AM a treatment cart was observed with a computer screen unlocked. Resident 82's information was visible including her/his code status, allergies, and care to be provided. Staff were not at the cart. On 1/29/26 at 10:51 AM Staff 15 (IP) was observed to lock the computer screen.On 1/29/26 at 10:51 PM Staff 7 (LPN) stated she/he was in charge of the treatment cart, and the computer screen should be locked. On 2/2/26 at 10:08 AM Staff 2 (DNS) stated staff were to lock the computer screens before leaving the cart. 2. On 1/26/26 at 4:10 PM a medication cart computer screen was observed with Resident 105's medication list visible. Staff were not within sight of the cart. Staff 16 (CMA) was observed to exit a resident room. Staff 16 stated the computer screen was to be locked when not in use. Staff 16 stated he was called away from the computer and did not lock the computer screen before leaving the cart. On 2/2/26 at 10:08 AM Staff 2 (DNS) stated staff were to lock the computer screens before leaving the cart.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review it was determined the facility failed to ensure resident toilets were repaired timely for 1 of 7 sampled residents (#15) reviewed for environment. This placed residents at risk for an unhomelike environment. Findings include: Resident 115 was admitted to the facility in 3/2025 with a diagnosis of chronic lung disease.Resident 115's Significant Change MDS revealed she/he was cognitively intact. On 1/26/26 at 12:24 PM Resident 115 stated when the toilet flushed at night, it made a really loud noise, and it scared [her/him' to death.On 1/28/26 at 12:10 PM Staff 16 (CNA) stated Resident 115's toilet was very loud when flushed and was loud for approximately two months. Staff 16 stated if equipment needed to be repaired maintenance was notified with an online communication system. On 1/28/26 at 12:12 PM with Staff 6 (Maintenance) Resident 115's toilet was flushed and was heard to make a loud foghorn like noise. Staff 6 stated he was not aware and was not notified by staff that Resident 115's toilet was loud when flushed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review it was determined the facility failed to develop and implement comprehensive care plans for 1 of 3 sampled residents (# 92) reviewed for activities. This placed residents at risk for unmet needs. Findings include:Resident 92 was admitted to the facility in 12/2025 with diagnoses including alcohol abuse and encephalopathy (a disease in which the brain is affected by toxins or infection in the blood).Resident 92's 12/16/25 admission MDS indicated Resident 92 was at risk for isolation, depression, and further decline. he MDS further indicated Resident 92 will be referred to activities to avoid isolation.The 1/11/26 revised care plan failed to address Resident 92's preferences, likes, dislikes, and activities to avoid isolation.On 1/26/26 at 3:57 PM Resident 92 stated she/he was not aware of any activities in the facility and would like to participate.On 1/28/26 at 3:19 PM Resident 92 was observed sitting in the hallway alone.On 1/29/26 at 12:30 PM Resident 92 was observed eating lunch in her/his room alone.Random observations from 1/29/26 through 2/2/26 on day and evening shifts revealed Resident 92 sitting in her/his room or walking the halls alone.On 1/26/26 at 10:38 AM Staff 39(CNA) stated the resident did not participate in the facility but did mention she/he would like to try the music exercise. Staff CNA stated she did not know if the resident actually went.On 1/26/26 at 3:57 PM Resident 92 stated she/he was not aware of any activities in the facility and would like to participate.On 1/30/26 at 10:57 AM Staff 42 (LPN) stated she was not aware if Resident 92 participated in the activities provided in the facility but was aware she/he walked around the facility.On 1/30/26 at 1:50 PM Staff 23 (Activities Director) acknowledged the care plan was not comprehensive.On 1/30/26 at 2:04 PM Staff 2(DNS) stated her expectation was for the (RCMs) and Staff to work together to provide preferences and activities for the residents and have a comprehensive care plan to reflect the resident's preferences.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review it was determined the facility failed to ensure appropriate interdisciplinary team members were present for resident care conferences, failed to ensure care plans were updated to reflect current status, and failed to hold care planning meetings for 3 of 6 sampled residents (#s 5, 30, and 71) reviewed for dentures and care planning. This placed residents at risk for lack of care planning participation and unmet care needs. Findings include: 1. Resident 5 was admitted to the facility in 3/2024 with a diagnosis of heart disease. Resident 5's Care Plan updated on 9/19/25 revealed she/he was at risk for ADL self-care. Interventions included bilateral bed canes for mobility. On 1/27/26 at 3:14 PM Resident 5 was observed in a recliner. Resident 5 did not have a bed in her/his room. On 1/29/26 at 2:53 PM Staff 3 (RNCM) stated Resident 5 did not have a bed for a while, and the care plan was not updated to reflect the changes. On 2/2/26 at 10:08 AM Staff 2 (DNS) stated care plans were to be updated at least quarterly, with a change of condition, and as needed to reflect current care. 2. Resident 30 was admitted to the facility in 9/2025 with diagnoses including heart failure and diabetes. The 9/22/25 and 11/15/25 IDT (Interdisciplinary Team) Care Plan Conference Evaluations revealed Staff 18 (Assistant Social Worker) was present at the meeting, social services needs were addressed with Resident 30, no additional staff were present at the meetings, and no nursing subject matter was documented as discussed. The 1/7/26 Quarterly MDS revealed a BIMS assessment score of 12 (moderate cognitive impairment) for Resident 30. A 1/10/26 Hemoglobin A1c (a laboratory test measuring the average glucose level over three months) Clinical Report revealed Resident 30's diabetes was well controlled. On 1/27/26 at10:28 AM, Resident 30 stated she/he wanted to address concerns regarding heart medication changes and a desire for a Hemoglobin A1c but did not. Resident 30 could not recall any IDT meetings to discuss medical concerns when a nurse was present. Resident 30 stated she/he was not aware of any Hemoglobin A1c results which was necessary to understand changes in her/his diabetic medications. On 1/30/26 9:45 AM, Staff 18 stated invitations for Resident 30's care conferences were not sent out timely to those staff who were to attend her/his meetings. The expectation was for concerns of residents to be addressed at care conference and for team members to attend to address issues and resident questions. On 1/30/26 at 10:08 AM, Staff 19 (Unit Manager-LPN) acknowledged she did not attend the last two care conferences for Resident 30. Staff 19 expected any medical concerns to be addressed and documented during care conferences and communicated to those who could not attend. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/26 at 10:39 AM, Staff 2 (DNS) stated Unit Mangers and other IDT team members were to attend care conference meetings and, if unavailable, a representative needed to attend the meetings to address the resident's care concerns. 3. Resident 71 was admitted to the facility in 8/2023 with a diagnosis of kidney disease. On 1/27/26 at 9:27 AM Resident 71 stated she did not have dentures and was observed to not have teeth. Resident 71's Care Plan revised on 10/14/25 revealed she/he did not have teeth, and staff were to assist with denture care. On 1/30/26 at 8:36 AM Staff 31 (CNA) stated he never saw Resident 71's dentures. On 1/29/26 at 2:53 PM Staff 3 (RNCM) stated she was not aware Resident 71 did not have dentures and indicated the care plan did not reflect her/his current dental status needs. On 2/2/26 at 10:08 AM Staff 2 (DNS) stated care plans were to be updated at least quarterly, with a change of condition, and as needed to reflect current care.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interview and record review it was determined the facility failed to provide a Restorative program for 1 of 1 sampled resident (#55) reviewed for restorative. This placed residents at risk for increased weakness. Findings include: Resident 55 was admitted to the facility in 9/2024 post joint replacement. Resident 55's Care Plan revised on 9/26/25 revealed she/he had limited mobility, and interventions include a nursing restorative program. The program included walking. Resident 55's 12/22/25 Quarterly MDS revealed she/he was cognitively intact. On 1/26/26 at 11:22 AM Resident 55 stated she/he received exercises and then it suddenly stopped. Resident 55's clinical record did not have documentation to indicate she/he currently received a restorative program or a rationale for discontinuation. On 1/29/26 at 10:29 AM Staff 5 (Director of Rehabilitation) stated Resident 55 was not on the current list of residents who received restorative services. On 1/29/26 at 11:05 AM Staff 33 (Restorative Aide) stated Resident 55 had a respiratory illness and restorative was discontinued. Staff stated she informed the RNCM. On 1/30/26 at 1:39 PM Staff 3 (RNCM) stated Resident 55 had a respiratory illness and Staff removed her/him from services. Staff 3 stated if a resident's restorative program was discontinued there should be a note for the rationale. Staff 3 stated there was no assessment or rationale for the discontinuation of Resident 55's restorative program. On 2/2/26 at 10:08 AM Staff 2 (DNS) stated after therapy develops a restorative program for a resident, it is then nursing driven and the RNCM should be involved with the decisions to discontinue a resident's program.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation interview and record review it was determined the facility failed to ensure personal hygiene was provided for 1 of 4 sampled residents (#55) reviewed for ADLs. This placed residents at risk for poor hygiene. Findings include: Resident 55 was admitted to the facility in 9/2024 with a diagnosis of joint replacement. Resident 55's 12/22/25 Quarterly MDS revealed she/he was cognitively intact. Resident 55's Care Plan last revised on 9/26/25 revealed she/he had an ADL self-care performance deficit and interventions included she/he was dependent on staff for personal hygiene. On 1/26/26 at 11:17 AM Resident 55 stated she/he needed assistance to shave and preferred to be clean shaven. Resident 55 also stated she/he did not receive many showers. Resident 55 was observed in bed and was not shaved. Resident 55's facial hair was approximately 0.25 inches long. An undated facility shower schedule revealed Resident 55's shower days were scheduled for Tuesday and Thursday mornings. Resident 55's 12/31/25 through 1/21/26 shower documentation and Progress Notes revealed the following:-12/31/25- Resident 55 refused a shower. There was no progress note to indicate nursing communicated with her/him.-1/2/26- Resident 55 was offered two times, and a progress note indicated she/he would accept a shower on another day.-1/3/26 (Saturday) Resident 55 received a shower -1/5/26 (Monday) Resident 55 refused a shower. There was no progress note to indicate nursing communicated with her/him.-1/6/26 Resident 55 refused a shower. There was no progress note to indicate nursing communicated with her/him.-1/7/26- Resident 55 refused a shower on two occasions. There was no progress note to indicate nursing communicated with her/him.-1/9/26 Resident 55 refused a shower on two occasions. There was no progress note to indicate nursing communicated with her/him.-1/14/26 Resident 55 received a shower-1/21/26 Resident 55 refused a shower. There was no progress note to indicate nursing communicated with her/him.Resident 55 received two showers in 30 days. On 1/30/26 at 8:33 AM Staff 34 (CNA) stated if a resident refused a shower, the resident was to be offered assistance two more times that day. If a resident refused a shower after the third offer, the nurse was notified, and the nurse was to communicate with the resident. Staff 34 stated residents were usually shaved on shower days. On 1/30/26 at 8:39 AM Staff 34 (LPN) stated if a resident refused a shower, the CNA was to notify the nurse, and the nurse was to communicate with the resident to offer an alternative shower day and was also to encourage the resident to bathe. On 1/30/26 at 1:39 PM Staff 3 (RNCM) stated Resident 55 often refused showers and her/his shower days were changed. Staff 3 stated Resident 55's care plan did not address her/his shaving preference and acknowledged if staff shaved residents on shower days, Resident 55 would not be shaved often. On 2/2/26 at 10:08 AM Staff 2 (DNS) stated a resident's shower, and shaving preferences were to be determined upon admission. If a resident refused a shower the nurse should find out the reason for the refusal and document in the resident's clinical record. Staff 2 stated she did not see documentation for shower refusals.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record it was determined the facility failed to provide meaningful activities for dependent residents for 1 of 3 sampled residents (#61) reviewed for activities. This placed residents at risk for lack of social interaction and isolation. Findings include: Resident 61 was admitted to the facility in 11/2025 with diagnoses including dementia, post-traumatic seizures, and anxiety. The 11/11/25 admission MDS indicated a BIMS assessment score of 15 (cognitively intact) and Resident 61 was unable to complete her/his interview for her/his Preferences for Routine and Activities. The MDS indicated staff knew it was important for Resident 61 to participate in religious activities, spend time outdoors and do things with groups of people.A 11/14/25 Care Plan indicated staff were to invite the resident to leisure programs. No information about Resident 61's preferences for activities were identified. The 12/28/25 through 1/27/26 Task: Activity Involvement document revealed Resident 61 was not offered activities during the last 30 days.On 1/27/26 at 9:40 AM, Resident 61 was observed sitting alone on her/his bed in her/his room, the resident indicated no staff interviewed her/him regarding her/his preferences for activities, and the resident was interested in bingo. On 1/28/26 at 11:39 AM, Staff 21 (CNA) stated no information about Resident 61's preferences for activities were in her/his care plan and the resident liked to stay secluded in her/his room.On 1/28/26 at 11:47 AM, Staff 24 (Activity Assistant) stated she was not surprised she did not know Resident 61. Staff 24 revealed she offered books to residents who were on the skilled wing. Staff 24 stated when residents decline books or room activities, we move on.On 01/28/26 at 12:01 PM, Staff 23 (Activity Assistant) stated she interviewed Resident 61 about her/his activities preferences, and the resident was able to answer all the questions. Staff 23 stated she did not complete care plans for activities and was aware she did not correctly complete Resident 61's admission MDS due to lack of training. Staff 23 stated she perceived Resident 61 was anxious during her/his interview, religious and group activities were important to the resident, and acknowledged follow-up with Resident 61 for activities did not occur. Staff 23 expected CNAs to offer activities and communicate when a resident was interested to attend. Staff 23 acknowledged improved communication between CNAs and activity staff was necessary. On 1/29/26 at 3:02 PM, Staff 1 (Administrator) acknowledged training was needed for activity staff. Staff 1 expected correct information about Resident 61's activities and preferences in the MDS, and care plan and activities offered to Resident 61 based on those preferences.

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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 ensure a resident's smoking paraphernalia was stored securely and failed to ensure a resident was evaluated for safety after a fall for 1 of 3 sampled residents (#71) reviewed for smoking and falls. This placed residents at risk for injury. Findings include.Resident 71 was admitted to the facility in 8/2023 with a diagnosis of paraplegia. Resident 71's 1/2/26 BIMS revealed she/he was cognitively intact.1. A Smoking -Supervised Smokers policy last revised 12/2025 revealed residents who wish to smoke were to be evaluated. Smoking paraphernalia would be managed by nursing staff and made available during smoking times. Resident 71's Care Plan last revised on 12/31/25 revealed she/he was an independent smoker. Interventions included cigarettes and lighters were required to be stored at the nurse's station. On 1/27/26 at 9:32 AM Resident 71 was observed in the smoking area. Resident 71 had a black bag in her/his lap. When Resident 71 opened her/his bag one pack of cigarettes and one lighter was observed. On 1/29/26 8:45 AM Staff 38 (CNA) stated Resident 71 smoked in the morning with other residents. Staff 38 stated Resident 71 was allowed to smoke without supervision. Staff 38 stated Resident 71 kept her/his lighter in her/his black bag. On 1/29/26 at 9:14 AM Staff 3 (RNCM) stated Resident 71 was assessed to be able to smoke independently. Staff 3 was not aware Resident 71 kept her/his lighter and cigarettes in her/his black bag, but stated it was likely the reason she never saw Resident 71 obtain her/his smoking paraphernalia from the nurses station. On 2/2/26 at 10:02 AM Staff 1 (Administrator) stated staff were to monitor residents who smoke. The designated smoking area had locked boxes for residents to store their smoking paraphernalia. Staff 1 stated residents were not always compliant with storing smoking supplies. 2. Resident 71's Power Wheelchair or Scooter Safety Skills Assessment Supplement form revealed she/he was safe to use a power wheelchair. Resident 71's 12/31/25 Unwitnessed Fall investigation revealed she/he fell on [DATE]. Resident 71 was in her/his power wheelchair and reported she/he unbuckled her/his seatbelt prior to the fall. The investigation revealed she/he sustained a brain bleed. Actions taken to prevent further occurrences were to have OT evaluate Resident 71 in her/his chair to see if a different type of chair or adjustments to the current chair were appropriate for her/his safety. Resident 71's 1/7/26 OT Evaluation and Plan of Treatment revealed she/he was referred to OT after a fall from her/his wheelchair after she/he removed the seal belt resulting in a brain bleed and leg fracture. Resident 71 also reported left shoulder pain. The OT assessment evaluated the resident's ability to sit at the edge of the bed. The assessment did not include an evaluation of the wheelchair to see if adaptations could be made for safety. The assessment indicated continued OT services were not needed. Resident 71's 1/7/26 PT Evaluation and Plan of Care revealed she/he was assessed after she/he fell two times after unbuckling her/his seat belt. The first fall resulted in facial fractures and the second fall resulted in a small brain bleed and a left hip fracture. The evaluation indicated resident 71 was not able to use her/his leg for six weeks and no ROM or exercise program was appropriate. The evaluation also indicated Resident 71 had extensive education by staff to use the seatbelt when in the chair. It was determined continued PT services were not indicated. The evaluation did not include an assessment to determine if additional adaptations could be made to Resident 71's power wheelchair for safety. On 1/29/26 at 9:14 AM and at 2:53 PM Staff 3 (RNCM) stated Resident 71 fell two times in 12/2025 because she/he unbuckled her/his seatbelt. After the fall OT was to evaluate the power chair to see if there was anything which could increase her/his safety. On 1/29/26 at 2:31 PM Staff 5 (Director of Rehabilitation) stated in 2025 Resident 71 was evaluated for the use of her/his power wheelchair and was assessed to be safe. Staff 5 stated after the falls therapy evaluated Resident 71, but the order did not indicate it was to evaluate wheelchair safety, and she/he was assessed for physical needs.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review the facility failed to effectively manage the resident's pain for 1 of 3 (#66) sampled residents reviewed for pain management. This placed residents at risk for unmanaged pain. Findings include: Resident 66 was admitted to the facility in 2022 with diagnoses including severe osteoarthritis (a disease which destroys the cartilage protecting bones and cause pain, stiffness and reduced mobility) and chronic pain. The resident's 11/2025 BIMS revealed a score of 14 (cognitively intact).A review of the resident's pain monitoring (1-10 scale of pain level with 10 indicating the worst pain possible) in the TAR for the previous 12 months revealed the following:2/2025: Pain levels of 6-10 reported on 26 of 28 days.3/2025: Pain levels of 6-9 reported on 27 of 31 days.4/2025: Pain levels of 6-10 reported on 28 of 30 days.5/2025: Pain levels of 6-10 reported on 30 of 31 days. 6/2025: Pain levels of 6-8 reported on 25 of 30 days. 7/2025: Pain levels of 6-8 reported on 25 of 31 days.8/2025: Pain levels of 6-8 reported on 30 of 31 days.9/2025: Pain levels of 6-9 reported on 23 of 30 days.10/2025: Pain levels of 6-9 reported on 28 of 31 days.11/2025: Pain levels of 6-8 reported on 25 of 30 days.12/2025: Pain levels of 6-8 reported on 26 of 31 days.1/2026: Pain levels of 6-7 reported on 26 of 28 days. Resident 66's clinical record revealed orders for Tylenol, Lyrica (a medication used to treat nerve pain), lidocaine patches, and cyclobenzaprine (a muscle relaxer) for pain. In a Pain Assessment completed 12/23/25 by Staff 7 (LPN) the resident reported severe pain that interfered with sleep, activity, and participation in therapy. The report indicated the resident reported an acceptable pain level would be a level five.On 1/27/26 at 8:25 AM, Resident 66 stated she/he had chronic, unrelieved pain and the only thing she/he could do was lay completely still as movement usually exacerbated the pain. The resident stated she/he received opioid pain medication in the past but was taken off of it due to using a marijuana gummy. The resident stated she/he used the marijuana gummy because she/he was desperate to stop the pain and nothing was working. The resident stated she/he had no quality of life and felt frustrated, trapped and hopeless. On 1/28/26 at 8:45 AM, the resident was observed in her/his room with ice packs on her/his right shoulder. The resident was in tears and stated the shoulder pain was severe. On 2/1/26 at 12:49 PM, Staff 39 (CMA) stated Resident 66 had chronic pain in her/his shoulders and back and she sometimes found Resident 66 crying from pain. On 2/1/26 at 3:17 PM, Staff 7 stated he did a Pain Assessment for Resident 66 on 12/23/25 and was very familiar with the resident. Staff 7 stated in the past year Resident 66 experienced pain experienced significant pain 4 out of 5 days. Staff 7 stated he wrote an SBAR (an internal communication which does not become part of the clinical record) sometime after the assessment as the resident had reported a pain level of ten out of ten. He stated he was aware she/he was chronically in pain and did not think her/his pain regimen of Tylenol and Lyrica was alleviating her/his pain. Staff 7 stated Resident 66 was more independent in the past but now was dependent on staff for most of her/his care. On 2/1/26 at 4:45 PM, Staff 16 (CMA) stated Resident 66 experienced was in a lot of pain chronically. Staff 16 stated he saw Resident 66 in tears from pain frequently and she/he would cry out in pain when she/he tried to move. Staff 16 stated he spoke to the Unit Manager about Resident 66's pain.On 2/1/26 at 6:47 PM, Staff 38 (CNA) stated Resident 66 was chronically in pain and she would see Resident 66 crying or grimacing in pain. She stated Resident 66 rarely left her/his room and wanted to be left alone when she/he was in a lot of pain. She stated she would attempt comfort measures with Resident 66 and sometimes she could distract her/him but didn't really think anything was helping alleviate Resident 66's pain. On 2/2/26 at 11:18 AM, Staff 37 (Physician's Assistant) stated the resident had severe osteoarthritis. She stated Resident 66 was on a pain contract from a previous provider and refused a urinalysis which meant she/he was weaned off opioids. Staff 37 stated Resident has severe osteoarthritis and a hernia and was not a candidate for corrective surgery due to her/his weight. Staff 37 stated Resident 66 could find another provider, but she was not going to risk her license by prescribing Resident 66 opioids since she/he violated the pain contract. On 2/2/26 at 11:28 AM, Staff (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8 (Social Services Director) stated Resident 66's last interdisciplinary team conference was in 2/2025. Staff 8 stated he did not assist Resident 66 to obtain an appointment with a pain management clinic.On 2/2/26 at 11:38 AM, Staff 28 (LPN/Unit Manager) stated Resident 66 reported her/his pain was not managed but when Staff 28 asked staff they reported Resident 66 did not present symptoms of pain. Staff 28 stated staff did not inform her Resident 66's pain regimen was not effective and she did not interview Resident 66 about her/his pain. Staff 28 stated she had heard Resident 66 used methamphetamine and violated her/his pain management contract. Staff 28 stated she did not request Resident 66 be evaluated for substance use disorder (SUD) and was not aware there was no diagnosis for SUD in Resident 66's clinical record. On 2/2/26 at 11:50 AM, Staff 2 (DNS) stated the facility had an obligation to provide oversight and care of residents and collaborate regularly on the effectiveness of resident care. Staff 2 stated the facility needed to review Resident 66's situation and to assist Resident 66 to reach her highest practicable level of wellbeing.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review it was determined the facility failed to thoroughly assess a resident with trauma for 1 of 2 sampled residents (#61) reviewed for behaviors. This placed residents at risk for re-traumatization. Findings include:Resident 61 was admitted to the facility in 11/2025 with diagnoses including insomnia, post-traumatic seizures, and anxiety. The 11/11/25 admission MDS indicated a BIMS score of 15 (cognitively intact) for Resident 61. The 11/11/25 ACTs My Way assessment indicated Resident 61 was sensitive to loud noises due to military service and Staff 23 (Activity Assistant) conducted the interview.A 11/14/25 Care Plan revealed no information about Resident 61's PTSD (Post Traumatic Stress Disorder) triggers. The 1/2026 Monitors revealed Resident 61 slept from two to 11 hours per day during the month. On 1/27/26 at 10:05 AM, Resident 61 stated she/he had PTSD and no one was aware he/she required a particular environment to sleep well. Resident 61 sat at the side of her/his bed with the television on and stated she/he needed sound in the room with the television on and the drapes tucked against the window to ensure no person was looking in from the outside. Resident 61 stated it was helpful to the resident for staff to know that information in order to feel safe.On 1/27/26 at 4:13 PM, Staff 20 (CNA) stated she was aware Resident 61 was afraid of the dark, needed the shades closed, and she reported the issue to nursing. On 1/28/26 at 12:01 PM, Staff 23 acknowledged Resident 61 was uneasy when she interviewed the resident about her/his PTSD. Staff 23 did not report any concerns to nursing and was unsure how information was communicated to CNAs in order to improve care for Resident 61. On 1/29/26 at 4:13 PM, Staff 9 (Director of Social Services) stated he expected communication from staff when Resident 61 indicated she/he had triggers related to PTSD. Staff 9 acknowledged Resident 61 lacked a thorough assessment and expected interventions in the resident's care plan to ensure the resident felt safe.

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	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Rehabilitation Health Center	1735 Adkins Street Eugene, OR 97401

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review it was determined the facility failed to provide dental services for 1 of 3 sampled residents (#5) reviewed for dental. This placed residents at risk for weight loss and unmet dental needs. Findings include: Resident 5 was admitted to the facility in 3/2024 with a diagnosis of diabetes. Resident 5's 3/19/25 health care provider summary revealed Resident 5 was seen for chronic conditions and her/his dental status. The summary indicated Resident 5 requested to see a dentist for possible implants. Resident 5's 1/20/26 NP Wound Note reveals she/he had mild cognitive impairment. Resident 5's 1/27/26 Care Plan revealed she/he did not have teeth, and staff were to refer to a dentist for evaluations. On 1/26/26 at 3:58 PM Resident 5 stated she/he did not have teeth and wanted implants. Resident 5 stated no one spoke to her/him forever regarding dental services. On 1/29/26 at 2:53 PM Staff 3 (RNCM) stated Resident 5 was able to be transported to dental appointments, but she did not see any dental referrals in her/his clinical record.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review it was determined the facility failed to ensure consents were obtained prior to administering an influenza vaccine to 2 of 5 sampled residents (#s 9 and 62) reviewed for vaccinations. This put residents at risk for not being informed of their rights. Findings include:1. Resident 9 admitted to the facility in 1/2023 with diagnoses including paralysis of the left side following a stroke and diabetes. An 10/23/25 Quarterly MDS indicated Resident 9 was cognitively intact.A review of Resident 9's medical record indicated she/he received an influenza vaccine on 10/2/25. No consent for the influenza vaccine was found in Resident 9's medical record. On 1/29/26 at 2:44 PM, Staff 15 (RN/IP) stated all residents were offered influenza vaccines when they were available, and a consent was signed prior to receiving the vaccine. She verified Resident 9 did not have a signed consent for the influenza vaccine she/he received on 10/2/25.On 2/2/26 at 1:04 PM, Staff 2 (DNS) stated she expected all nursing staff to obtain a signed consent prior to giving any vaccinations. 2. Resident 62 admitted to the facility in 6/2024 with diagnoses including end stage renal disease and paralysis of the left side following a stroke. A 12/21/25 Quarterly MDS indicated Resident 62 was cognitively intact. A review of Resident 62's medical record indicated she/he received an influenza vaccine on 10/7/25. No consent for the influenza vaccine was found in Resident 62's medical record. On 1/29/26 at 2:44 PM, Staff 15 (RN/IP) stated all residents were offered influenza vaccines when they were available, and a consent was signed prior to receiving the vaccine. She verified Resident 62 did not have a signed consent for the influenza vaccine she/he received on 10/7/25.On 2/2/26 at 1:04 PM, Staff 2 (DNS) stated she expected all nursing staff to obtain a signed consent prior to giving any vaccinations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review it was determined the facility failed to ensure consents were obtained prior to administering a COVID-19 vaccine to 2 of 5 sampled residents (#s 9 and 62) reviewed for vaccinations. This put residents at risk for not being informed of their rights. Findings include:The facility Infection Prevention & Control COVID-19 Immunization policy with revision date 1/7/25 indicated all residents would be offered the COVID-19 vaccine when available and the resident's medical record would contain documentation of an acceptance or refusal of the vaccine. 1. Resident 9 admitted to the facility in 1/2023 with diagnoses including paralysis of the left side following a stroke and diabetes. An 10/23/25 Quarterly MDS indicated Resident 9 was cognitively intact.A review of Resident 9's medical record indicated she/he received a COVID-19 vaccine on 10/2/25. No consent for the COVID-19 vaccine was found in Resident 9's medical record. On 1/29/26 at 2:44 PM, Staff 15 (RN/IP) stated all residents were offered COVID-19 vaccines when they were available, and a consent was signed prior to receiving the vaccine. She verified Resident 9 did not have a signed consent for the COVID-19 vaccine she/he received on 10/2/25.On 2/2/26 at 1:04 PM, Staff 2 (DNS) stated she expected all nursing staff to obtain a signed consent prior to giving any vaccinations. 2. Resident 62 admitted to the facility in 6/2024 with diagnoses including end stage renal disease and paralysis of the left side following a stroke. A 12/21/25 Quarterly MDS indicated Resident 62 was cognitively intact.A review of Resident 62's medical record indicated she/he received a COVID-19 vaccine on 10/7/25. No consent for the COVID-19 vaccine was found in Resident 62's medical record. On 1/29/26 at 2:44 PM, Staff 15 (RN/IP) stated all residents were offered COVID-19 vaccines when they were available, and a consent was signed prior to receiving the vaccine. She verified Resident 62 did not have a signed consent for the COVID-19 vaccine she/he received on 10/7/25.On 2/2/26 at 1:04 PM, Staff 2 (DNS) stated she expected all nursing staff to obtain a signed consent prior to giving any vaccinations.