STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385232	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Hill Nursing Center	859 NE 6th Street Grants Pass, OR 97526

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 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. Based on interviews and record review it was determined the facility failed to follow physician orders for wound care interventions for 1 of 3 sampled resident's (# 101) reviewed for coordination of wound care. This placed residents at risk for unmet wound care needs. Findings include:Resident 101 was admitted to the facility in 2024 with diagnoses including a Stage 4 pressure ulcer (most severe form of pressure injury characterized by full-thickness tissue loss with exposed fascia, muscle, tendon or bone) to the sacrum (triangular bone at the base of the spine connecting the spine to the pelvis), and stroke. On 5/7/25 a BIMS evaluation indicated Resident 101 had a BIMS score of 14 and was cognitively intact. A 5/28/25 Wound Ostomy Clinic Progress Note indicated Resident 101's wound healing had stalled, and an order was faxed to the facility for the resident to get a wheelchair seat mapping completed. The order also included the facility should schedule Resident 101's seat mapping appointment. A 5/28/25 Progress Note revealed the resident returned from wound care with a new order for a wheelchair seat mapping related to pressure injury of the sacral region. The order faxed to the vendor on 5/28/25 at 11:05 AM. On 5/30/25 at 11:03 AM, Witness 1 (Nurse Practitioner) reported Resident 101 was her/his patient at the local wound clinic. Witness 1 stated on 5/28/25 she/he ordered a seat mapping for a new wheelchair cushion due to a previous cushion (Roho cushion) she/he had ordered being removed from the resident's use. When Witness 1 checked on 5/30/25 the seat mapping for the new cushion had still not been ordered or completed. A 6/19/25 Progress Note indicated a nurse called the vendor that morning for an update on the seat mapping. The vendor requested the order be faxed. A 7/29/25 Progress Note indicated staff called the vendor and they had not received any faxes from the facility. It was confirmed the facility had faxed to the incorrect fax number. On 1/27/26 at 3:13 PM, Staff 2 (DNS) provided a timeline for the 5/28/25 seat mapping for a new wheelchair cushion order. In 7/2025, the facility refaxed the referral. Staff 2 indicated that both sides attempted to contact each other but was unsuccessful. In 8/2025, a vendor nurse requested the facility to re-fax the information. Staff 2 stated the vendor failed to explain the cushion needed to be billed directly to the facility and not to the resident's insurance. Staff 2 stated they scheduled an appointment for Resident 101 on 2/13/25 at 1:00 PM, 10 months after the original order was received. Staff 2 indicated they had dropped the ball by not following up on the order promptly and she was putting a new procedure in place to ensure there was appropriate follow-up on orders.

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