

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Hillside Heights Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 McLean Blvd. Eugene, OR 97405	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, it was determined the facility failed to investigate a potential case of abuse and investigate a fall in a timely manner for 2 of 4 sampled residents (#103 and 113) reviewed for accidents and abuse. This placed residents at risk for abuse and neglect. Findings include:1 Resident 103 was admitted to the facility in 5/2024 with diagnoses including unsteadiness on feet, and traumatic brain injury.An Unwitnessed Fall investigation revealed on 5/28/24 at 8:27 PM, Resident 103 sustained a fall while attempting to go outside the facility. The report indicated the investigation was completed on 6/10/24.On 11/5/25 at 11:33 AM Staff 2 (DNS) stated investigations are expected to be completed by staff within five days.2. Resident 113 was admitted to the facility in 11/2024 with diagnoses including stroke and anxiety.A 11/8/24 hospital History and Physical report revealed Resident 113 was a poor historian and mostly responded with, I do not remember.A 11/14/24 SLUMS (St. Louis University Mental Status Examination - a test that checks memory, language and thinking skills) completed for Resident 113 revealed a score of six. A score between zero and 20 indicates dementia.A 11/18/24 admission MDS indicated Resident 113 was rarely understood and had both short-term and long-term memory problems.A 12/13/24 physician order directed staff to obtain a sexually transmitted infection (STI) risk panel laboratory test. A 12/26/24 Encounter Note written by Staff 32 (Former Doctor of Nursing Practice) indicated Resident 113 had foul smelling vaginal discharge which was off-white and chunky. STI testing could not be completed at the facility. Resident 113 completed a round of antibiotics for a UTI with no improvement. Staff 32 recommended sending Resident 113 to the emergency department for faster laboratory results.On 12/27/24, the State Agency received a public complaint alleging Resident 113 had been diagnosed with a sexually transmitted disease.A 12/29/24 hospital Discharge Summary revealed Resident 113 was diagnosed with trichomonal vaginitis (a sexually transmitted infection).No documentation was found in Resident 113's clinical record of an investigation into potential sexual abuse for Resident 113.On 11/5/25 at 8:30 AM, Staff 32 stated Resident 113 reported to her she had not been sexually active in the facility but had been sexually active before admission.On 11/5/25 at 11:41 AM, Staff 1 (Administrator) stated he expected staff to complete an investigation into possible sexual abuse for Resident 113.</p>		

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: 385046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Hillside Heights Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 McLean Blvd. Eugene, OR 97405	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review it was determined the facility failed to maintain a safe environment free from accident hazards for 1 of 3 sampled residents (#103) reviewed for accidents. This placed residents at risk for injury. Findings include: Resident 103 was admitted to the facility in 5/2024 with diagnoses including unsteadiness on feet and traumatic brain injury. A baseline care plan initiated on 5/20/24 indicated Resident 103 experienced two falls on 5/20/24. Interventions included a PT consultation for strength and mobility, one on one activities if bed bound, and monitoring for bruising, changes in mental status, confusion, and sleepiness. An Unwitnessed Fall investigation dated 5/21/24 revealed at 3:11 AM, Resident 103 rolled out of bed onto the floor. The brakes on both beds in the resident's room were not functioning properly. The incident was considered avoidable due to the bed malfunction. On 11/3/25 at 9:05 AM, Staff 18 (Maintenance Director) stated the bed brakes were checked monthly in the facility. Staff 18 confirmed there was no documentation to verify the checks were completed and no work orders from 5/1/24 through 6/30/24 related to malfunctioning bed brakes. On 11/4/25 at 10:40 AM, Staff 14 (Former LPN Unit Manager) confirmed Resident 103's bed wheel brakes were not functioning at the time of Resident 103's fall on 5/21/24. On 11/5/25 at 11:33 AM, Staff 2 (DNS) stated staff were expected to check bed wheel brakes before leaving a resident's room to ensure they were locked.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Hillside Heights Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 McLean Blvd. Eugene, OR 97405	

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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observation, interview, and record review it was determined the facility failed to provide assistance with eating as care planned for 1 of 3 resident (#112) reviewed for hydration. This placed residents at risk for unmet needs. Findings include: Resident 112 was admitted to the facility in 2/2025 with diagnoses including dysphagia and dementia. A 10/3/25 Quarterly MDS indicated Resident 112 required supervision or touch assistance with eating. A revised care plan dated 9/3/25 revealed Resident 112 had an ADL self-care performance deficit and was dependent on staff to eat. Resident 112 fed herself/himself some of the time but was not consistent and required assistance. In a continuous observation on 11/3/25 at 12:31 PM Resident 112 was observed sitting up in bed with a food tray in front of her/him. He was unable to answer questions, and no staff were observed in room. At 12:45 PM Staff 6 (CNA) was observed walking by Resident 112's room and did not check on Resident 112. At 12:47 PM Staff 6 went into Resident 112's room and asked if she/he was all done and Resident 112 stated I don't know. Staff 6 stated it looks like it and left the room with the food tray. The plate still had approximately 90 percent of the food on the plate. On 11/5/25 at 10:39 AM Staff 6 confirmed she was assigned to Resident 112 on 11/3/25. Staff 6 stated Resident 112 was care planned for eating with the assistance of one person and needed supervision. Staff 6 stated the one person was there to provide queuing to eat. Staff 6 stated on 11/3/25 she may have been sitting in the room with Resident 112, but she did not remember. On 11/5/25 at 11:38 AM Staff 2 (DNS) stated the staff working with Resident 112 on 11/3/25 did not know Resident 112 and confirmed she/he required assistance to eat.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Hillside Heights Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 McLean Blvd. Eugene, OR 97405	
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)		
<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>Based on interview and record review it was determined the facility failed to process physician laboratory orders timely for 1 of 1 sampled resident (#113) reviewed for abuse. This placed residents at risk for untreated medical needs. Findings include: Resident 113 was admitted to the facility in 11/2024 with diagnoses including stroke and anxiety. A 12/13/24 physician order instructed staff to obtain a sexually transmitted infection (STI) risk panel laboratory test. A 12/14/24 risk panel report indicated no test was specified on the requisition (official request form) for the specimen. The report requested the test code and corresponding test name for the specimen received. The STI increased risk panel required an Aptima swab (A device designed for the collection of samples from various specimen sites to detect infections.) The word URGENT appeared in large letters across the page. A 12/16/24 Encounter Note written by Staff 32 (Former Doctor of Nursing Practice) revealed Resident 113 had foul smelling vaginal discharge and the STI test was denied by the lab. UTI testing was positive, and the plan was to treat as a UTI and follow up as needed for ongoing concerns for the STI. A 12/18/24 STI Increased Risk Panel indicated the test was not performed as no suitable specimen was received. The report directed staff to review the test requirements on the laboratory's website. A 12/20/24 Nursing Note indicated Resident 113 experienced hallucinations. Resident 113 reported she/he had not experienced hallucinations in the past. A 12/26/24 Encounter Note written by Staff 32 indicated Resident 113 had foul smelling vaginal discharge which was off-white and chunky in nature. Unable to obtain STI testing in the facility. Resident 113 completed a round of antibiotics for a UTI with no improvement in symptoms. The best option would be to send Resident 113 out the emergency department for evaluation and access to faster laboratory results. On 11/5/25 at 8:30 AM, Staff 32 stated she was frustrated about Resident 113's STI laboratory testing. Staff 32 reported the facility informed her the lab testing was not within the financial budget. She explained the lab company used by the facility would refuse certain tests, and it was a battle to get lab testing completed. On 11/5/25 at 11:41 AM, Staff 2 (DNS) stated he was unsure what occurred with Resident 113's laboratory results.</p>		