STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385046	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Center	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)
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 interview, and record review, it was determined the facility failed to ensure ongoing assessments were conducted for non-pressure skin wounds for 1 of 3 sampled residents (#4) reviewed for non-pressure skin wounds. This placed residents at risk for worsening wounds. Findings include: A review of the facility's Skin and Wound Management Guidelines indicated the following skin changes required assessment, measurement, photography, and documentation in the Skin and Wound Module:-Neuropathic ulcer (nerve related sore).-Infected skin tear, regardless of size.-All vascular-related wounds (wounds due to blood vessels), venous or arterial. Resident 4 was admitted to the facility in 11/2025 with diagnoses including open wound of left great toe and diabetes with polyneuropathy (a condition where many nerves in the body are damaged, causing numbness, weakness, or pain in the hands and feet). The 11/20/25, admission MDS indicated Resident 4 was cognitively intact and had a diabetic foot ulcer. A Wound Clinic Note dated 11/20/25 indicated Resident 4 had a blister that was incised (cut into the skin with a sharp tool) on the left great toe with minimal to moderate amount of drainage. Total wound surface area was 20 cm^2 or less. A Skin and Wound Evaluation dated 11/24/25 indicated Resident 4 had an other wound on the first digit of the left foot measuring 10.06 cm, with a length of 5 cm and a width of 2.7 cm. The wound bed showed epithelial (new skin), granulation (healing tissue) and slough (dead tissue) layers, but did not indicate percentage of each. The wound had moderate amounts of serosanguineous (clear and blood-tinged) drainage. Resident 4's evaluation did not include an assessment of the resident's wound edges, swelling, temperature, pain, treatment type and the care goal.A 12/11/25 Wound Clinic Note indicated Resident 4's left great toe wound had regressed and was aggressively debrided. The tissue debrided was callus (hardened skin), fibrin (protein build-up) and slough. There was no documented evidence in Resident 4's clinical record of further Skin and Wound Evaluations being completed after 12/11/25. On 4/2/26 the State Survey agency received a public complaint alleging Resident 4 had an infected toe due to facility negligence. Approximately 24 hours after discharge, a nurse became ill after examining the wound and reported black edges. Resident 4 was sent to the hospital and placed on IV antibiotics. On 4/7/26 at 10:06 AM, Resident 4 confirmed the above complaint and stated her/his toe was still painful. On 4/8/26 at 11:22 AM and 12:21 PM, Staff 3 (LPN) confirmed she completed wound care on the left great toe the day before discharged on 12/30/25. She recalled slight amount of dried blood but no black discoloration. She noted blanchable (temporary) redness but no infection. Staff`3 stated weekly wound assessments were set to trigger automatically on admission and the wound nurse typically completed evaluations. On 4/8/26 at 12:31 PM, Staff 2 (DNS) stated he expected staff to complete weekly skin and wound assessments for residents. Staff 2 stated because of budget cuts the facility no longer had a wound nurse, and it was difficult for nurses to complete the weekly evaluations.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, it was determined the facility failed to provide adequate catheter care for 1 of 3 sampled residents (#1) reviewed for catheter care. This placed residents at risk for unmet catheter needs. Resident 1 was admitted to the facility in 12/2025 with diagnoses including obstructive and reflux uropathy (disease of the urinary system caused by blockage and backward urine flow). The 1/2026 TAR indicated for staff to change the suprapubic catheter every 30 days. On 1/12/26 the TAR indicated to hold the treatment and referred the reader to Administration Notes. A 1/12/26 Administration Note indicated the suprapubic catheter was not changed because staff were waiting for pending special instructions from the in-house provider because of a penile implant (device surgically inserted into the penis). There was no documented evidence that Resident 1 received a suprapubic catheter change in 1/2026. Resident 1's 2/2026 TAR indicated for staff to change the suprapubic catheter every 30 days. On 2/11/26 the TAR indicated the catheter was changed by Staff 10 (LPN). Review of Resident 1's progress notes found no documentation of the resident's 2/11/26 suprapubic catheter change. A 2/18/26 Nursing Note documented Resident 1 had notified Staff 3 (LPN) of bladder pain and spasms. Resident 1 requested a urinalysis as she/he believed there was an infection. Physician orders signed 2/19/26 directed staff to complete a urinalysis. On 2/19/26 the State Survey agency received two public complaints indicating Resident 1 had been at the facility since 12/2025 and the suprapubic catheter had not been changed since admission. Resident 1 believed there was a urinary tract infection. Review of Resident 1's clinical record found no documentation the resident received the ordered urinalysis. On 4/8/26 at 11:17 AM, Staff 3 stated she had not been sure whether the catheter should be changed in the facility or at the urology clinic. Staff 3 stated she did not work on 1/13/26 and did not know if Resident 1 received a catheter change in 1/2026. On 4/8/26 at 12:15 PM, Staff 10 stated she did not recall ever completing a catheter change on Resident 1. She stated usually she would normally document the treatment in the notes. Staff 10 stated she most likely documented she completed the suprapubic change but did not complete the treatment. On 4/8/26 at 12:28 PM, Staff 2 (DNS) stated documentation was lacking on the follow-through related to communication in 1/2026 regarding the penile implant and changing of the suprapubic catheter orders. Staff 2 stated he did not believe Resident 1 had a penile implant and staff had mistaken the suprapubic catheter for an implant. Staff 2 stated Resident 1 had developed chest pain and pneumonia, and staff focused on the pneumonia instead of the physician-order urinalysis, resulting in failure to perform the urinalysis. Staff 2 confirmed physician ordered treatment was not completed.