| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385046 | A. Building<br>B. Wing | 01/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hillside Heights Rehabilitation Center | 1201 McLean Blvd.<br>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.

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review it was determined the facility failed to ensure proper labeling of biologicals for 2 of 3 treatment carts reviewed for medication storage and failed to ensure treatment carts were properly secured during a random observation. This placed residents at risk for reduced efficacy of medication and unauthorized access to medications. Findings include:1. On 1/28/26 observations were made from 11:21 AM to 11:31 AM of the treatment cart on the west hall near the nurses' station, it was left unlocked and unattended.On 1/28/26 at 11:31 AM Staff 8 (LPN) acknowledged the treatment cart was left unlocked and unattended and contained insulin and other treatments.2. On 1/28/26 at 11:34 AM on open insulin glargine pen was observed in the west hall treatment cart with no open date.On 1/28/26 at 11:34 AM Staff 8 (LPN) acknowledged the insulin pen was open and not labeled with an open date.3. On 1/28/26 at 12:54 PM one open Tresiba insulin pen was observed in the east hall treatment cart with no open date.On 1/28/26 at 12:54 PM Staff 7 (RN) acknowledged the insulin pen was open and not labeled with an open date. |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interview and record review it was determined the facility failed to follow the facility bowel protocol and administer medication as ordered for 2 of 5 sampled residents (#s 5 and 8) reviewed for medication. This placed residents at risk for constipation. Findings include:The undated bowel protocol indicated residents without a bowel movement in excess of three days would be assessed by the nurse, including a physical assessment of the gastro-intestinal (GI) system, signs and symptoms of constipation, impaction, or obstruction, and complete a resident and/or staff interview. When needed, a bowel protocol would be implemented as established by physician orders including administration of stool softeners, administration of laxatives or bowel stimulants, and administration of an enema. If after completion of the bowel protocol orders, the resident did not have a bowel movement, the physician would be notified. 1. Resident 5 admitted to the facility in 12/2025 with diagnoses including diabetes. A review of the bowel records from 12/31/25 through 1/28/26 indicated the resident did not have a bowel movement on 1/3/26, 1/4/26, 1/5/26, 1/6/26 and 1/7/26.A review of the 1/3/26 through 1/7/26 progress notes and MARs indicated no bowel assessments were completed, and additional bowel medications were not offered to the resident. On 1/29/26 at 2:13 PM Staff 2 (DNS) acknowledged a bowel assessment was not completed for Resident 5 and she/he did not receive bowel care interventions as ordered on the identified dates.2. Resident 8 admitted to the facility in 12/2025 with diagnoses including heart failure.A review of the bowel records from 1/1/26 through 1/29/26 indicated the resident did not have a bowel movement on 1/19/26, 1/20/26, 1/21/26 and 1/22/26.A review of the 1/19/26 through 1/22/26 progress notes and MARs indicated no bowel assessments were completed, and additional bowel medications were not offered to the resident.On 1/30/26 at 10:57 AM Staff 2 (DNS) acknowledged a bowel assessment was not completed for Resident 8 and she/he did not receive bowel care interventions as ordered on the identified dates. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview and record review it was determined the facility failed to ensure residents' narcotic drug records were in order and an account of all controlled drugs was maintained for 2 of 3 medication carts reviewed for medication storage. This placed residents at risk for inaccurate clinical records related to narcotics and drug diversion. Findings include:1. On 1/28/26 at 8:38 AM the west hall Controlled Substance Book was reviewed with Staff 8 (LPN). There was only one signature observed for the 1/28/26 day shift controlled medication count. Staff 8 immediately signed the book and stated he completed the count earlier that morning with another staff, but did not sign the book.On 1/30/26 at 11:39 AM Staff 2 (DNS) stated the expectation was for two staff to count controlled medications between shifts, compare them to the Controlled Substance Book and each sign the signature page after the count was completed.2. On 1/28/26 at 9:23 AM Staff 7 (RN) was observed to administer oxycodone (controlled medication) to Resident 19. Staff 7 signed out the oxycodone from the Controlled Substance Book. There were only four pills remaining after the administration, but the book indicated there were five remaining. Staff 7 stated she completed the controlled medication count with the night shift nurse but they missed the discrepancy between the oxycodone medication card and the book.On 1/30/26 at 11:39 AM Staff 2 (DNS) stated the expectation was for each responsible staff to count controlled medications between shifts and compare them to the Controlled Substance Book to ensure accuracy. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on interview and record review the facility failed to ensure residents were free from unnecessary medications for 1 of 5 sampled residents (#5) reviewed for medication. This placed residents at risk for adverse drug events. Findings include:Resident 5 admitted to the facility in 12/2025 with diagnoses including atrial fibrillation.The 12/19/25 physician order indicated Resident 5 was to receive digoxin (antiarrhythmic) 250 mcg once daily.The manufacturer recommendations indicated to monitor the heart rate for one full minute before administration and notify the health care provider if the heart rate was less than 60 beats per minute or any significant changes in rate, rhythm or quality of the pulse.There was no indication in the clinical record that staff monitored Resident 5's heart rate each time before administering digoxin.On 1/29/26 at 12:45 PM Staff 7 (RN) stated she held the medication if the pulse was below 60 beats per minute, but did not always check the pulse before administering digoxin. Staff 7 stated if the CNAs recently checked the pulse and it was recorded in the electronic health record, then she administered the medication using that data. On 1/29/26 at 12:53 PM Staff 9 (LPN) stated Resident 5 did not have parameters for digoxin noted in the electronic health record. Staff 9 stated she held the medication if the resident's heart rate was in the 50s. Staff 9 further stated she looked at the CNA vital signs recorded in the electronic health record and administered the medication if the CNAs checked the pulse within the last hour.On 1/29/26 at 1:15 PM Staff 2 (DNS) acknowledged Resident 5 had an order for digoxin with no parameters noted in the clinical record. Staff 2 stated staff were to check the resident's pulse before administering digoxin and hold it if the pulse was too low. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview and record review it was determined the facility failed to maintain a medication error rate of less than 5%. There were 2 errors in 27 opportunities resulting in a 7% error rate. This placed residents at risk for adverse medication side effects. Findings include:Resident 46 admitted to the facility in 2019 with diagnoses including atrial fibrillation.The 1/22/26 physician order indicated Resident 46 was to receive the following:-Lasix every Monday, Wednesday and Friday for lower extremity edema;-Lactulose once daily for increased ammonia levels.On 1/28/26 at 8:42 AM Staff 7 (RN) was observed to administer morning medications to Resident 46. The medications administered did not include Lasix or Lactulose.On 1/28/26 at 8:54 AM Staff 7 acknowledged Resident 46 did not receive Lasix and Lactulose as ordered because the medications were not available. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>Based on interview and record review it was determined the facility failed to provide dental services for 1 of 3 sampled residents (#7) reviewed for dental services. This placed residents at risk for unmet dental needs. Findings include:Resident 7 admitted to the facility in 2023 with diagnoses including heart failure.The 11/6/25 progress note indicated Resident 7 had poor dentition.The 11/26/25 Care Conference indicated Resident 7 was interested in having a dental appointment. On 1/26/26 at 1:59 PM Resident 7 stated she/he had dental problems and requested to see the dentist at the last care conference several months ago but staff did not follow up on the request. There was no information in the clinical record to indicate a follow up was completed for Resident 7's request to see the dentist.On 1/29/26 at 2:13 PM Staff 2 (DNS) acknowledged Resident 7 indicated she/he wanted to see the dentist at the 11/26/25 care conference and a dental appointment was not set up for the resident. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on interview and record review it was determined the facility failed to ensure medical records were accurate for 1 of 5 sampled residents (#5) reviewed for medication. This placed residents at risk for medication errors. Findings include: Resident 5 admitted to the facility in 12/2025 with diagnoses including atrial fibrillation.The 12/19/25 physician order indicated Resident 5 was to receive digoxin 250 mcg once daily.The 12/2025 and 1/2026 MARs indicated Resident 5 was to receive digoxin 250 mg from 12/20/25 through 12/31/25 and from 1/1/26 through 1/8/26.On 1/29/26 at 1:15 PM Staff 2 (DNS) stated there was a transcription error when digoxin was entered into the MARs and acknowledged the MARs indicated the resident was to receive digoxin 250 mg when the order was for digoxin 250 mcg. |