

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Creekside Health and Rehab of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 Hilyard Street 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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure a resident was treated with dignity and respect for 1 of 4 sampled residents (#16) reviewed for abuse. This placed residents at risk for lack of dignity and respect. Findings include:</p> <p>Resident 16 was admitted to the facility in 3/2025, with diagnoses including anxiety.</p> <p>An admission MDS dated [DATE] indicated Resident 16 was cognitively intact.</p> <p>The Baseline Care Plan dated 3/28/25, indicated Resident 16 used anti-anxiety medications, with interventions including she/he could become overwhelmed. Staff could assist with one-on-one support. Resident 16 required moderate assistance of one staff member for stand pivot transfers and toileting.</p> <p>A 3/29/25 facility investigation was initiated after two residents complained about Staff 5 (Former CNA). Multiple grievances against Staff 5 led to him being placed on administrative leave. Resident 16 filed a grievance on 3/29/25, which detailed an incident on 3/28/25 during the evening or night shift. Resident 16 reported she/he had requested a female CNA to assist with her/his shower, to which Staff 5 responded one was not available and you're not my type. During assistance with toileting and assisting Resident 16 into bed a call light fell off the bed. Resident 16 reported Staff 5, with clenched teeth and after getting close to her/his face stated, I don't understand you fucking people leaving your shit on the bed. Resident 16 also stated Staff 5 folded her/his walker and threw it in the corner of the room. Resident 16 reported Staff 5 was angry about her/him needing to use the potty, and Staff 5 refused to deal with her/him. Staff 5 got a urinal and stated, fucking tired of this, then told Resident 16 to put her/his legs on the bed. Resident 16 was too slow; Staff 5 reportedly grabbed her/his legs and roughly tossed them on the bed. While Resident 16 used the urinal, Staff 5 kept ranting. An item dropped behind the bed, and Staff 5 became scary, clenching his teeth and getting into Resident 16's face saying, what's wrong with you fucking people. You put your personal shit all over your bed. Staff 5 then pulled the bed out and found the call light. Resident 16 was crying, and Staff 5 stated she/he did not need to cry and patted her/his hand. The investigation indicated Staff 5 reported he was in a hurry on 3/28/25 and felt he may have been short but never intended to be.</p> <p>(continued on next page)</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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/12/25 at 9:19 AM, Staff 5 (Former CNA) stated he did not remember Resident 16. Staff 5 denied throwing the walker, though he conceded he might have inadvertently moved a walker quickly, causing it to hit a wall. Staff 5 also admitted he might have inadvertently used profanity in a resident's room and not intentionally moved a resident's legs roughly. Staff 5 mentioned numerous complaints from multiple residents at the facility and stated he resigned as there was no resolution.</p> <p>On 6/12/25 at 10:12 AM, Staff 6 stated she heard residents complain about Staff 5, describing him as gruff with the residents and was rough around the edges.</p> <p>On 6/12/25 at 10:38 AM, Resident 16 stated on the night of 3/28/25 a male CNA came into her/his room to assist her/him with toileting. Resident 16 stated she/he asked for a female caregiver and Staff 5 informed her/him there was no female CNA available and stated, you are not my type. Resident 16 stated Staff 5 assisted her/him with toileting and getting into bed. Staff 5 folded up the walker and he threw it, and it hit hard. Resident 16 stated she/he was frightened. Staff 5 stated he did not have time for this bull shit and picked Resident 16 up and plopped her/him on the bed. Resident 16 stated he picked her/him up from underneath the arm pits and he was very strong. During the time he put her/him into the bed an object fell behind the bed. Staff 5 was very close to her/his faced and stated, I am so fucking sick of you guys putting stuff on the end of the bed. Resident 16 stated it scared her/him. Staff 5 picked up the items behind the bed, patted Resident 16 on the back and told her/him everything was okay.</p> <p>On 6/12/25 at 11:53 AM, Staff 2 (DNS) and Staff 3 (Regional RN Consultant) stated the facility ruled out abuse and neglect as Resident 16's story would go back and forth with her/his statement. Staff 2 stated she felt everything was resolved with Resident 16.</p> <p>The deficient practice was identified as Past Noncompliance based on the following:</p> <p>On 3/31/25, the deficient practice was identified by the facility and was corrected when the facility completed an investigation and identified system failures in the identification of potential abuse and neglect. The Plan of Correction included:</p> <p>*On 3/31/25, Staff 7 (RN) was educated on abuse and neglect policies, along with grievances which could potentially rise to the level of an allegation of abuse or neglect which should be reported to the Administrator immediately.</p> <p>*Ten additional residents were interviewed. All indicated they felt safe at the facility and vocalized no concerns regarding staff care and services.</p> <p>*Staff 5 was provided education regarding communication and perception of communication by others. Staff 5 was provided a work plan which included access to counseling services and offered additional time off. Staff 5 was assigned training, which included Stress Management and Building up Emotional Intelligence. This training must be completed prior to returning to the facility along with abuse and neglect training.</p> <p>*All staff educated on grievances and understanding that grievances could potentially rise to the level of alleged abuse or neglect along with the facility's reporting abuse and neglect policy.</p>		