STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385147	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Health and Rehabilitation of Cascadia	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview it was determined the facility failed to maintain a homelike environment for 1 of 1 facility reviewed. This placed residents at risk for living in an uncomfortable and un-homelike environment. Findings include: Resident 38 was admitted to the facility in 2023 with a diagnosis of quadriplegia.On 5/19/26 at 10:11 AM, Resident 38 stated the carpets were stained in several spots and needed to be replaced.On 5/21/26 at 10:12 AM, observation of all facility halls revealed multiple areas of stained and discolored carpeting throughout resident hallways. Large dark stains were observed on the carpeted walking surfaces. Multiple light-colored bleach stains were observed adjacent to resident room doorways. The carpets appeared worn, dingy and discolored, resulting in an unclean appearance.On 5/21/26 at 10:12 AM, Staff 7 (Maintenance Director) observed the 400, 600, and 700 halls confirmed the carpets were stained in multiple areas, large dark stains were observed in the carpet, and multiple light colored bleach stains were observed adjacent to resident rooms. The Maintenance Director acknowledged the carpeting was stained and discolored.On 5/21/26 at 11:03 AM, Staff 1 (CEO) acknowledged the carpets needed to be replaced.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to store medications properly for 1 of 3 medication refrigerators. This placed residents at risk for receiving ineffective medication. Findings include:The CDC requires medication refrigerators to always maintain a temperature between 36 and 46 degrees Fahrenheit (F).On 5/21/26 at 1:37 PM, Staff 2 (DNS/CNO) provided the temperature log for the facility's narcotic refrigerator for the last 30 days. The temperatures were as follows:-4/21/26 at 7:00 AM 25.16 degrees F-4/21/26 at 7:00 PM 28.04 degrees F-4/22/26 at 7:00 AM 30.2 degrees F-4/22/26 at 7:00 PM 28.58 degrees F-4/23/26 at 7:00 AM 28.4 degrees F-4/23/26 at 7:00 PM 27.68 degrees F-4/24/26 at 7:00 AM 25.88 degrees F-4/24/26 at 7:00 PM 27.5 degrees F-4/25/26 at 7:00 AM 25.34 degrees F-4/25/26 at 7:00 PM 27.5 degrees F-4/26/26 at 7:00 AM 24.08 degrees F-4/26/26 at 7:00 PM 29.48 degrees F-4/27/26 at 7:00 AM 25.16 degrees F-4/27/26 at 7:00 PM 27.86 degrees F-4/28/26 at 7:00 AM 26.42 degrees F-4/28/26 at 7:00 PM 24.98 degrees F-4/29/26 at 7:00 AM 27.5 degrees F-4/29/26 at 7:00 PM 25.7 degrees F-4/30/26 at 7:00 AM 28.58 degrees F-4/30/26 at 7:00 PM 31.1 degrees F-5/1/26 at 7:00 AM 25.7 degrees F-5/1/26 at 7:00 PM 26.6 degrees F-5/2/26 at 7:00 AM 26.6 degrees F-5/2/26 at 7:00 PM 31.1 degrees F-5/3/26 at 7:00 AM 30.74 degrees F-5/3/26 at 7:00 PM 31.64 degrees F-5/4/26 at 7:00 AM 25.88 degrees F-5/4/26 at 7:00 PM 26.42 degrees F-5/5/26 at 7:00 AM 31.1 degrees F-5/5/26 at 7:00 PM 27.14 degrees F-5/6/26 at 7:00 AM 31.1 degrees F-5/6/26 at 7:00 PM 28.4 degrees F-5/7/26 at 7:00 AM 27.5 degrees F-5/7/26 at 7:00 PM 27.86 degrees F-5/8/26 at 7:00 AM 29.12 degrees F-5/8/26 at 7:00 PM 23.9 degrees F-5/9/26 at 7:00 AM 30.56 degrees F-5/9/26 at 7:00 PM 30.02 degrees F-5/10/26 at 7:00 AM 25.88 degrees F-5/10/26 at 7:00 PM 28.76 degrees F-5/11/26 at 7:00 AM 29.3 degrees F-5/11/26 at 7:00 PM 25.16 degrees F-5/12/26 at 7:00 AM 26.24 degrees F-5/12/26 at 7:00 PM 25.52 degrees F-5/13/26 at 7:00 AM 28.4 degrees F-5/13/26 at 7:00 PM 30.02 degrees F-5/14/26 at 7:00 AM 30.02 degrees F-5/14/26 at 7:00 PM 25.34 degrees F-5/15/26 at 7:00 AM 26.78 degrees F-5/15/26 at 7:00 PM 28.04 degrees F-5/16/26 at 7:00 AM 24.8 degrees F-5/16/26 at 7:00 PM 25.34 degrees F-5/17/26 at 7:00 AM 29.48 degrees F-5/17/26 at 7:00 PM 29.3 degrees F-5/18/26 at 7:00 AM 28.04 degrees F-5/18/26 at 7:00 PM 27.5 degrees F-5/19/26 at 7:00 AM 26.42 degrees F-5/19/26 at 7:00 PM 25.52 degrees F-5/20/26 at 7:00 AM 26.06 degrees F-5/20/26 at 7:00 PM 26.24 degrees F-5/21/26 at 7:00 AM 25.88 degrees [NAME] 5/21/26 at 3:19 PM, Staff 2 stated medication refrigerator temperatures are taken automatically every 12 hours and when the temperature is out of range, she gets a notification on her phone. On 5/21/26 at 3:24 PM, the narcotic refrigerator was observed with Staff 2. The narcotic refrigerator contained an unopened bottle of liquid lorazepam (an antianxiety medication), an unopened vial of injectable lorazepam, and an open bottle of liquid lorazepam for a resident who discharged on 5/20/26. The resident received two doses of lorazepam, one dose on 5/19/26 and one dose on 5/20/26. Staff 2 stated the pharmacy was notified and the medications would be discarded. Staff 2 stated she expected if the temperature in the refrigerator was too low, the temperature would be turned up, and the medications in the refrigerator would be replaced. Staff 2 acknowledged this procedure was not followed and maintenance had not been notified of the low temperatures in the medication refrigerator.On 5/21/26 at 3:50 PM, Staff 14 (Pharmacist) stated lorazepam efficiency would be affected if kept in a refrigerator below freezing temperatures for that long.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide timely lab services for 2 of 5 sampled residents (#s 6 and 11) reviewed for unnecessary medications. This placed residents at risk for delayed treatment. Findings include: Resident 6 was admitted to the facility on [DATE] with a diagnosis of acute pyelonephritis (severe kidney infection). Resident 6's 4/2026 BIMS Assessment indicated a score of 15 (cognitively intact). A review of the resident's clinical record revealed on 3/6/26 Resident 6 reported burning with urination for a couple of days to Staff 12 (NP). Staff 12 ordered a UA for Resident 6. Additional notes revealed the specimen was sent to the lab 3/6/26. No documentation was located in the clinical record of the lab results for the 3/6/26 urine sample. On 5/21/26 at 10:30 AM, Staff 4 (IP) stated the facility was notified by the lab on 3/10/26 the resident's name was not identifiable on the specimen. The clinical record revealed a new order was obtained for a UA on 3/12/26, and a new urine specimen was obtained and sent to the lab on 3/13/26. The resident's clinical record revealed she/he discharged [DATE]. Lab results were not returned to the facility until 3/17/26. The clinical record revealed Resident 6 returned to the hospital on 3/18/26 after a fall. Hospital records indicate the resident was diagnosed with a UTI while in the hospital. On 5/21/26 at 3:22 PM, Staff 10 (LPN) stated nurses are responsible for obtaining urine samples. Staff 10 stated when a resident was reporting symptoms of a UTI it would be imperative to obtain a new sample and send it to the lab. Staff 10 stated the nurse on duty when the lab notified the facility should have called the on-call provider for a new order. Staff 10 stated a sample should be obtained and sent to the lab the same day. On 5/21/26 at 3:33 PM, Staff 11 (LPN/Unit Manager) stated the lab generally sends an email within 24 hours if they can't process a specimen. Staff 11 stated the Unit Manager and IP should know when a urine culture was ordered and monitor for a result. On 5/21/26 at 3:45 PM, Staff 9 (NP) stated she expected a nurse to call for a new order for a UA the same day they learned the specimen could not be processed. On 5/22/26 at 8:18 AM, Staff 2 (DNS) stated the original UA was collected by the facility on 3/6/26 and sent to the lab the same day. Staff 2 stated it was rejected by the lab, and the facility was informed on 3/10/26. Staff 2 stated a new culture was obtained and sent to the lab on 3/13/26. She stated she expected facility staff to follow up. 2. Resident 11 was admitted to the facility in 4/2026 with a diagnosis of a shoulder fracture. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 11's 4/17/26 Provider Visit Note revealed she/he had a suspected UTI with urine retention and the orders included to send a urine sample to evaluate for infection. Resident 11's Final Diagnostic report revealed her/his urine sample was collected on 4/17/26 and was not received at the laboratory until 4/21/26. Resident 11's urine sample results indicated she/he had many bacteria in the urine and a culture was to be completed. Resident 11's culture notes indicated the specimen quality was inadequate, and the culture was not performed because the urine sample exceeded the stability required for the test. On 5/19/26 at 3:17 PM, Staff 4 (Infection Preventionist) stated on 4/17/26 (Friday) Resident 11's urine sample was collected and placed in the laboratory box for the laboratory currier to pick up, but the specimen was still in the box on 4/20/26 (Monday). Staff 4 stated this was likely the reason the sample was inadequate. On 5/21/26 at 10:46 AM, Staff 2 (Chief Nursing Officer) stated when a resident's urine sample was collected., staff were to call the laboratory and request a currier pick up. Staff 2 stated at times the laboratory did not pick up the sample and the sample would need to be recollected.