

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Highland House Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 NW Highland Avenue Grants Pass, OR 97526	

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 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p>33179</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were treated with respect and dignity for 1 of 6 sampled residents (#12) reviewed for abuse. This placed residents at risk for being treated with a lack of respect and dignity. Findings include:</p> <p>Resident 12 admitted to the facility in 11/2024, with diagnoses including Parkinson's Disease. Resident 12 was on Hospice Services and passed away on 3/9/25.</p> <p>The 2/17/25 facility investigation revealed several staff attempted to assist Resident 12 to sit down in her/his wheelchair. Resident 12 displayed agitation, which included spitting on the ground and toward staff members. Staff 6 (CNA) flicked the resident on the back of her/his hand and stated, If you're going to be mean to me, I'm going to be mean to you. The resident experienced no negative outcome as a result of the interaction.</p> <p>The 2/18/25 Progress Note indicated Resident 11 was combative with staff and Hospice was notified of her/his behavioral changes.</p> <p>The 2/19/25 Progress Note indicated Resident 12 had possible psychosocial distress and increased agitation. Hospice was notified and new medication orders were received.</p> <p>On 4/2/25 at 2:30 PM, Staff 6 stated he flicked Resident 12 on the back of the hand and made the statement in attempt to be playful and calm the resident down. Staff 6 stated the resident was combative and he attempted to light the mood because they had a history of working together. Staff stated he was trying to be playful so Resident 12 would know staff were there to help her/him.</p> <p>On 4/2/25 at 10:45 AM, Staff 1 (Administrator) verified Resident 12 was not treated with respect or dignity by Staff 6.</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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179</p> <p>Based on interview and record review it was determined the facility failed to accurately assess facility acquired pressure ulcers for 1 of 3 sampled residents (#11) reviewed for skin conditions. This placed residents at risk for unassessed and worsening pressure ulcers. Findings include:</p> <p>The National Pressure Injury Advisory Panel defined shearing as a pressure injury when tissue layers moved over the top of each other, and a Stage 3 pressure ulcer as a full thickness tissue loss where subcutaneous fat may be visible but bone, tendon or muscle are not exposed and some slough (dead tissue often appearing as a yellow, tan, or white fibrous material) may be present but does not obscure the depth of tissue loss.</p> <p>Resident 11 was admitted to the facility in 1/2025, with diagnoses including intestinal bypass and failure to thrive. The resident discharged on [DATE].</p> <p>The 1/9/25 Nursing Admission Evaluation revealed Resident 11 had a red coccyx upon admission.</p> <p>The 1/11/2025 Admission MDS indicated Resident 11 was at risk for pressure ulcers and had no pressure ulcers.</p> <p>The 2/5/25 Wound Evaluation indicated Resident 11 had coccyx shearing. The evaluation indicated the wound had 90% granulation tissue, 10% slough, and light serosanguineous drainage. No wound measurements or staging were completed and the evaluation incorrectly indicated the wound was present on admission. The description of the wound described a Stage 3 pressure ulcer.</p> <p>On 4/2/25 at 3:20 PM, Staff 3 (LPN Unit Manager) acknowledged the skin wound evaluation incorrectly identified the coccyx wound as present on admission, the description of the wound defined a Stage 3 pressure ulcer and the assessment was not fully comprehensive.</p>

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<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>33179</p> <p>Based on interview and record review it was determined the facility failed to evaluate a potential unavoidable accident of a feeding tube being dislodged to prevent recurrence for 1 of 3 sampled residents (#11) reviewed for safety. This placed residents at risk for dislodged feeding tubes. Findings include:</p> <p>Resident 11 admitted to the facility in 1/2025, with diagnoses including failure to thrive and malnutrition.</p> <p>Resident 11's 1/9/25 Hospital Records revealed a J-tube (feeding tube inserted into stomach or small intestine) was surgically placed.</p> <p>The 1/11/25 Admission MDS revealed Resident 11 had a J-tube for enteral feedings (nutritional support).</p> <p>The 2/10/25 Progress Note indicated Staff 7 (CNA) transported Resident 11 to the shower room and when she removed the blanket, the J-tube dislodged and fell out. Staff 7 indicated the J-tube was intact when she placed a bath blanket over her/him in preparation to go to the shower room. The note further revealed an order was received to transfer the resident to the hospital for the J-tube replacement.</p> <p>Review of Resident 11's medical record revealed no documented evidence the resident's accident of her/his J-tube (feeding tube inserted into stomach or small intestine) dislodging was evaluated or investigated to determine how the resident's J-tube had dislodged and how to prevent recurrence.</p> <p>Staff 7 was not interviewed due to no contact information.</p> <p>On 4/2/25 at 2:00 PM, Staff 2 (DNS) stated she did not know how the J-tube dislodged and an incident report or facility investigation was not completed because the facility did not complete them for tubes that fell out.</p> <p>On 4/3/25 at 9:40 AM, Witness 12 (Family) stated staff reported when they pulled the blanket off Resident 11 they also pulled the J-tube out.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>33179</p> <p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 4 sampled residents (#13) reviewed for medications. This placed residents at risk for respiratory distress. Findings include:</p> <p>Resident 13 admitted to the facility in 3/2025, with diagnoses including failure to thrive. Resident 13 was on hospice services.</p> <p>Resident 13's 3/20/25 Progress Note indicated she/he was seen by a hospice nurse and the resident's methadone order was increased to 7.5 mg twice daily.</p> <p>Resident 13's 3/20/25 Hospice Order instructed staff to discontinue the previous order for methadone liquid 5 mg twice daily and to increase the methadone liquid 10 mg/ml to 7.5 ml to equal 7.5 mg by mouth every 12 hours for pain management (7.5 ml equaled 75 mg).</p> <p>The 3/2025 MAR indicated Resident 13 was administered 7.5 ml (75 mg) of Methadone on 3/20/25 at 8:00 PM by Staff 10 (CMA).</p> <p>Resident 13's 3/21/25 Hospice Orders included orders for Naloxone HCL nasal spray 4 mg one dose now (medication to reverse narcotic medication effects) and oxygen at 2 liters per minute prn for O2 sats less than or equal to 88%. The order also clarified the previous methadone order to specify 7.5 mg was 0.75 ml.</p> <p>Resident 13's 3/21/25 Progress Note indicated Naloxone HCL and oxygen were administered to the resident and the hospice nurse remained in the room for approximately one hour after medication administration.</p> <p>On 4/1/25 at 3:18 PM, Staff 10 (CMA) verified she gave Resident 13 7.5 ml of methadone instead of 0.75 ml. Staff 10 further stated when she saw the revised dose in the MAR she consulted with Staff 11 (Charge Nurse LPN) because she thought the new dose should be 0.75 ml. Staff 10 stated Staff 11 reviewed the original order and instructed Staff 10 to administer the medication as 7.5 ml to the resident.</p> <p>Staff 11 was contacted three times by telephone on 4/2/25 at 7:38 AM and 2:00 PM and 4/3/25 at 9:18 AM. Staff 11 did not respond to the voicemail requests for an interview.</p>		