STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
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 keep air temperatures between 71 and 81 degrees Fahrenheit for 2 of 4 halls reviewed for environment. This placed residents at risk for lack of a homelike environment. Findings include: On 9/30/25 at 9:34 AM, the thermostat in the 100 Hall displayed a temperature of 67 F. A second thermostat in the hall displayed a temperature of 68 F. On 9/30/2025 at 4:35 PM, Resident 106 stated her/his room was cold in the morning and she/he had to put on extra clothes. On 9/30/2025 at 4:42 PM, Resident 65 stated her/his room was very cold at times and stated her/his roommate, who could not be interviewed, frequently complained of being cold. On 12/2/25 at 9:00 AM, temperatures were taken in rooms 501, 505 and 506 by Staff 12 (Maintenance Director) and ranged from 66-68 F. Staff 12 stated hall thermostats being set too low was an ongoing problem in the facility. On 12/2/25 at 10:07 AM, Staff 24 (CNA) stated she received complaints from residents of rooms being too cold. On 12/2/25 at 10:09 AM, the thermostat in 500 Hall displayed a temperature of 68 F. On 12/2/25 at 10:15 AM, Resident 111 stated her/his room was always cold. On 12/2/25 at 10:24 AM, Staff 1 (Administrator) observed 500 Hall thermostats displaying temperatures below 71 F and stated he was very frustrated by the problem of low air temperatures in the facility and had to continually remind staff not to adjust thermostats.

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
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined the facility failed to ensure community use CBG monitors were cleaned with an Environmental Protection Agency approved disinfectant for 2 of 5 Halls (300 Hall and 400 Hall). This placed residents at risk for cross contamination. Findings include: 1. On 9/30/25 at 11:14 AM Staff 31 (CNA) was observed to clean a community use CBG monitor with an alcohol wipe. Staff 31 stated she always used the wipes to clean the monitors. Staff 31 stated Resident #s 5, 11, 61, 80, and 90 had CBGs checked. a. Resident 5 was admitted to the facility in 11/2025 with a diagnosis of diabetes. Resident 5's clinical record revealed she/he did not have a blood-borne pathogen diagnosis On 9/30/25 at 12:10 PM Staff 32 (Interim DNS) stated staff should not clean CBG monitors with alcohol wipes but with a disinfectant which killed blood-borne pathogens. b. Resident 11 was admitted to the facility in 9/2025 with a diagnosis of diabetes. Resident 11's clinical record revealed she/he did not have a diagnosis of a blood-borne pathogen. On 9/30/25 at 12:10 PM Staff 32 (Interim DNS) stated staff should not clean CBG monitors with alcohol wipes but with a disinfectant which killed blood-borne pathogens. c. Resident 61 was admitted to the facility in 8/2022 with a diagnosis of diabetes. Resident 61's clinical record revealed she/he did not have a diagnosis of a blood-borne pathogen. On 9/30/25 at 12:10 PM Staff 32 (Interim DNS) stated staff should not clean CBG monitors with alcohol wipes but with a disinfectant which killed blood-borne pathogens. d. Resident 80 was admitted to the facility in 8/2024 with a diagnosis of diabetes. Resident 80's clinical record revealed she/he did not have a diagnosis of a blood-borne pathogen. On 9/30/25 at 12:10 PM Staff 32 (Interim DNS) stated staff should not clean CBG monitors with alcohol wipes but with a disinfectant which killed bloodborne pathogens. e. Resident 90 was admitted to the facility in 11/2017 with a diagnosis of diabetes. Resident 90's clinical record revealed she/he did not have a diagnosis of a blood-borne pathogen. On 9/30/25 at 12:10 PM Staff 32 (Interim DNS) stated staff should not clean CBG monitors with alcohol wipes but with a disinfectant which killed bloodborne pathogens. 2. On 9/30/25 at 11:44 AM Staff 32 (CNA) stated she/he cleaned the community use CBG monitors with alcohol wipes. Residents who required diabetic monitoring were Resident 66 and 76. a. Resident 66 was admitted to the facility in 9/2025 with a diagnosis of diabetes. Resident 66's clinical record revealed she/he did not have a diagnosis of a blood-borne pathogen. On 9/30/25 at 12:10 PM Staff 32 (Interim DNS) stated staff should not clean CBG monitors with alcohol wipes but with a disinfectant which killed blood-borne pathogens. b. Resident 76 was admitted to the facility in 4/2019 with a diagnosis of diabetes. Resident 76's clinical record revealed she/he did not have a diagnosis of a blood-borne pathogen. On 9/30/25 at 12:10 PM Staff 32 (Interim DNS) stated staff should not clean CBG monitors with alcohol wipes but with a disinfectant which killed blood-borne pathogens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to ensure a resident's advance directive was in her/his clinical record for 1 of 1 sampled resident (#3) reviewed for advance directives. This placed residents at risk for end-of-life decisions not being honored. Findings include: Resident 3 was admitted to the facility in 2/2025 with a diagnosis of diabetes. Resident 3's 8/14/24 Care Conference form indicated she/he had an advance directive at home. There was no evidence Resident 3's advance directive was present in her/his clinical record. On 12/2/25 at 11:45 AM Staff 18 (Social Service Director) stated Resident 3 reported she/he had an advance directive at home, but her/his spouse did not bring it to the facility. Staff 18 stated she would follow up with the spouse at the next quarterly care conference to ensure she/he brought it to the facility. On 12/3/25 at 11:48 AM Staff 1 (Administrator) stated if a resident had an advance directive, it was to be in the resident's clinical file as soon as possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review it was determined the facility failed to ensure a resident's antipsychotic medication was not increased when adverse side effects were present for 1 of 4 sampled residents (# 92) reviewed for nutrition. This placed residents at risk for irreversible involuntary movements. Findings include: Resident 92 was readmitted to the facility in 8/2025 with a diagnosis of dementia. Resident 92's AIMS (Abnormal Involuntary Movement Scale) evaluations revealed on 1/11/25 she/he scored 2, on 8/15/25 she/he scored 7. The scale ranges from zero to 28, the higher the number, the greater the impact of involuntary movements on the resident. Resident 92's Progress Notes from 8/14/25 to 9/9/25 revealed the following:-8/15/25 Alert, able to make needs known. Pleasant and cooperative. -8/16/25 Alert, able to make needs known, and adjusting to the facility. Resident had tremors per baseline. -8/17/25 Alert, independent to eat.-8/24/25 Resident pressed her/his call light every 20 to 30 minutes requesting staff to assist with all her/his ADLs.-8/26/25 Resident reported she/he was doing well and had no complaints. There were no notes from 8/31/25 through 9/10/25. Resident 92's 9/2025 ADL report revealed behavior symptoms from 9/1/25 to 9/9/25 included 12 shifts with yelling, one shift with wandering, and two shifts with abusive language. Resident 92's 9/2025 TAR revealed no documented behaviors from 9/1/25 through 9/9/25 including paranoia, distressing delusions, hallucinations or yelling. Resident 92's 9/9/25 communication form from Staff 14 (LPN Resident Care Manager) to Staff 26 (NP) revealed the night staff reported Resident 92 yells out most of the night shift after 10:00 PM. Staff 14 requested Staff 26 assess Resident 92. A handwritten response by Staff 26 indicated Resident 92's antipsychotic medication was increased. Resident 92's 9/2025 MAR revealed she/he was administered Risperdal (antipsychotic) two mg in the morning and four mg in the evening from 9/1/25 through 9/8/25. The evening dose was increased to four mg on 9/9/25. Resident 92's 9/13/25's AIMS score was 10. Resident 92's 9/10/25 Progress Note-Follow up (NP note) revealed I had previously attempted to wean down her[/his] Risperdal and nursing reported increased behaviors screaming, delusions so I increased her[/his] dose back to where it was at her[/his] re-admission, she[/he] is noted to have increased lip smacking, head tremors.' The note also indicated a referral was placed for a psychiatry evaluation and medication management. The note also indicated Staff 26 observed Resident 92 in the past to have extreme episodes of paranoid delusions while not on Risperdal. On 10/2/25 at 8:19 AM Resident 92 was observed to attempt to bring her/his straw to her/his mouth but was not able bring the straw to her/his lips to drink. Resident 92 stated she/he wanted to drink but she/he was shaking too much. Resident 92's hands and head were observed to have involuntary movement. On 10/2/25 at 8:25 AM Staff 25 (CMA) stated Resident 92 had bad shakes. In the past, Resident 92 was able to feed her/himself. On 10/2/25 at 10:57 AM Staff 27 (CNA) stated at times Resident 92 yelled, but she/he was easily redirected. Staff 27 stated Resident 92 was able to make her/his needs known. Staff 27 stated at times Resident 92 spoke to someone in the room who was not present, but she/he was not distressed while talking. Staff 27 stated Resident 92 had shakes, and it was different each day, some days were worse than others. On 10/2/25 at 11:26 AM Staff 14 stated when she notified Staff 26 about Resident 92's behaviors she did not indicate she/he was hallucinating, but staff reported Resident 92 yelled. On 10/2/25 at 2:08 PM Staff 26 stated she initially saw Resident 92 during her/his previous admission. Historically, Resident 92 had behaviors including paranoid delusions, hallucinations, and she/he screamed. Resident 92 was on a higher dose of Risperdal during her/her previous admission, and the facility staff were able to decrease the dose before she/he was discharged from the facility. When resident 92 was re-admitted to the facility in 8/2025 an outside provider increased her/his Risperdal dose. Staff 26 stated on 9/9/25 facility staff reported Resident 92 yelled out, and when she/he was stable, she/he usually did not yell. Staff 26 stated she believed staff also reported Resident 92 was hallucinating. Staff 26 stated if she would have known the resident was easily redirected, she would not have increased the Risperdal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review it was determined the facility failed to ensure a resident's pressure ulcers were thoroughly investigated for 1 of 1 sampled resident (# 40) reviewed for hospice. This placed residents at risk for additional pressure ulcers. Findings include:Resident 40 was admitted to the facility in 6/2025 with a diagnosis of heart disease. Resident 40's Progress Notes revealed on 9/14/25 she/he was identified to have a pressure injury to the lower spine. The top of the wound had a small opening and treatment was provided. Resident 40's clinical record revealed she/he had two 9/15/25 Skin and Wound Evaluation forms. One revealed Resident 40 developed a facility acquired DTI (Deep Tissue Injury- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) located to the buttocks which was 7.5 cm long and 2.4 cm wide. The form indicated the skin was intact but discolored and new treatment orders were implemented. The second form revealed a facility acquired DTI to the spine which was 6.6 cm long and 2.6 cm wide. The form indicated the skin was intact but discolored and new treatment was implemented. Resident 40's 9/14/25 New Pressure Ulcer investigation indicated a new pressure injury was identified to her/his lower spine. the team review included Resident 40's diagnosis, immediate interventions. interventions to be added, and notifications. There was no root cause analysis to determine if this was an avoidable or unavoidable pressure ulcer, or if neglect of care was suspected. Resident 40's clinical record did not have an investigation for the DTI to the buttocks identified on 9/15/25. On 12/3/25 at 11:48 AM with Staff 1 (Administrator) and Staff 28 (Wound Nurse), Staff 1 stated the team worked together to complete the investigations to ensure the investigations were complete and the root cause analysis identified the cause of the problem to prevent re-occurrence. Staff 1 stated this was not done for Resident 40's 9/14/25 DTI investigation. Staff 28 stated the nurse who identified the 9/15/25 buttock DTI did not initiate an investigation; therefore, it was not completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined the facility failed to ensure the Office of the State Long-Term Care Ombudsman was notified of a resident's discharge or hospitalization for 3 of 3 sampled residents (#s 11, 98, and 100) reviewed for discharge and hospitalization. This placed residents at risk for lack of knowledge regarding their rights, choices and potential financial responsibilities. Findings include:1. Resident 11 was admitted to the facility in 9/2025 with diagnoses including stroke and respiratory failure. A review of Resident 11's clinical record revealed she/he was discharged to the hospital on 8/30/25 and discharged from the facility on 10/15/25. No evidence was found in the clinical record to indicate the Long-Term Care Ombudsman was notified of the resident's discharges on 8/30/25 and 10/15/25. On 12/1/25 at 1:57 PM, Staff 1 (Administrator) acknowledged the Long-Term Care Ombudsman was to be notified of discharges and transfers, and it was not clear who was responsible to complete the task within the facility. On 12/3/25 at 10:40 AM, Staff 18 (Social Worker) confirmed she was not aware of the required notification to the Long-Term Care Ombudsman for transfers or discharges. 2. Resident 98 admitted to the facility in 7/2025 with diagnoses including Methicillin Susceptible Staphylococcus Aureus infection (severe infection) and diabetes. A 7/26/25 admission MDS indicated Resident 98 was cognitively intact. A review of Resident 98's health record revealed she/he was hospitalized on [DATE]. No evidence was found in Resident 98's health record indicating the Office of the State Long-Term Care Ombudsman was notified of the resident's hospitalization. On 12/3/25 at 13:59, Staff 1 (Administrator) stated he was aware the Office of the State Long-Term Care Ombudsman's office should be contacted with all discharges and transfers to the hospital and acknowledged the facility had not notified the Office of the State Long-Term Care Ombudsman's office about Resident 98's hospitalization. 3. Resident 100 admitted to the facility in 7/2025 with diagnoses including fractured ribs and fractured left arm. A 7/7/25 admission MDS indicated Resident 100 was cognitively intact. A review of Resident 100's health record revealed she/he was discharged on 7/17/25. No evidence was found in Resident 100's health record indicating the Office of the State Long-Term Care Ombudsman was notified of the resident's discharge. On 12/3/25 @ 13:59, Staff 1 (Administrator) stated he was aware the Office of the State Long-Term Care Ombudsman's office should be contacted with all discharges and transfers to the hospital and acknowledged the facility had not notified the Office of the State Long-Term Care Ombudsman's office about Resident 100's discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review it was determined the facility failed develop a comprehensive care plan for 1 of 1 sampled resident (#9) reviewed for dialysis. This placed residents at risk for unmet dialysis needs. Findings include: Resident 9 was admitted to the facility in 5/2025 with a diagnosis of kidney disease. A 5/20/25 admission MDS indicated Resident 9 received dialysis Resident 9's Pre and Post Dialysis Assessment form revealed she/he had a central line to the right chest for dialysis access. Resident 9's comprehensive Care Plan Report initiated on 5/13/25 revealed she/he required dialysis. The care plan did not indicate the location of the access site or what to do if the access site came apart or was accidently pulled out. On 12/3/25 at 8:33 AM Staff 14 (LPN Resident Care Manager) verified the care plan did not have the access site identified and the care plan did not include what to do if there was an emergency related to the central line. On 12/3/25 at 11:48 AM Staff 1 (Administrator) acknowledged not all staff may know what to do if the emergency care was not on the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review it was determined the facility failed to revise care plan interventions for 1 of 1 sampled resident (#22) reviewed for position and mobility. This placed residents at risk for unmet needs. Findings include:Resident 22 was admitted to the facility in 7/2024 with diagnoses including chronic curvature of the spine, dementia, and repeat falls. The 7/28/25 Annual MDS revealed Resident 22 required a wheelchair for transportation and was dependent on staff for walking and transfers. The 10/2025 Documentation Survey Report indicated Resident 22 did not walk ten feet and was dependent on staff to ambulate for all recorded shifts. A 11/10/25 revised care plan indicated Resident 22 required the extensive assistance of one staff with the use of a walker to ambulate, used a cane for mobility and a sit to stand lift for transfers. Resident 22's care plan had no reference to the use of a pillow for positioning comfort. On 10/1/25 at 8:39 AM, Resident 22 was observed in bed eating breakfast from a bedside table. The resident leaned to her/his right side and a pillow was in place for support. There was no walker in the resident's room. On 12/2/25 at 10:03 AM, Staff 21 (CNA) stated Resident 22 leaned to her/his right side automatically, had pain during repositioning, and a pillow was used for her/his comfort. Staff 21 stated a Hoyer (hydraulic mechanical lift) was needed to transfer Resident 22 to her/his wheelchair and the resident had not used a walker for almost a year because she/he was unable to stand. On 12/2/25 at 1:17 PM, Resident 22 was observed sleeping and leaned to her/his right side in bed with no support. On 12/2/25 at 1:24 PM, Staff 19 (LPN) confirmed Resident 22 was more active six months earlier and Unit Managers were to update care plans for residents. On 12/3/25 at 9:57 AM, Staff 22 (CNA) stated she worked multiple halls and shifts and concluded Resident 22's care plan was inaccurate based on verbal information from other CNAs. Staff 22 stated she attempted to sit Resident 22 upright with no support to eat and confirmed the information about Resident 22's pain during repositioning and use of a pillow was needed in the care plan. Staff 22 stated it was an accident waiting to happen without accurate information regarding Resident 22's use of a Hoyer for transfers and need for a wheelchair to ambulate. On 12/3/25 at 11:56 AM, Staff 14 (Unit Manager-LPN) expected Staff 23 (MDS-RN) to compare MDS information and update the care plan each quarter. Staff were to compare the care that was provided to the resident to revise the care plan. Staff 14 acknowledged a review of Resident 22's care plan required a team approach and the resident's care plan was not accurate or revised in many areas. Staff 14 expected staff to notify her when a resident's care plan was not safe to ensure timely revisions. On 12/3/25 at 2:09 PM, Staff 2 (DNS) expected Staff 23 to interview staff and assess residents each quarter. Staff 2 expected care plans to address the specific care needs of each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, it was determined the facility failed to ensure a resident did not develop a pressure ulcer, failed to identify a pressure ulcer, and provide physician ordered treatments for 2 of 3 sampled residents (#s 3 and 76) reviewed for pressure ulcers. This placed residents at risk for delayed care and worsening pressure ulcers. Findings include: 1. Resident 3 was admitted to the facility in 2/2025 with diagnoses including diabetes, peripheral vascular disease (impaired circulation), and right hemiparesis (weakness) due to a stroke. Resident 3's 2/26/25 Admission/readmission Evaluation form revealed she/he was admitted to the facility without a pressure ulcer. Resident 3's Care Plan initiated on 2/26/25 revealed she/he required limited assisted with bed mobility, had peripheral vascular disease and her/his legs were to be elevated when sitting or sleeping (initiated 3/6/25). The care plan also directed staff to report new skin issues. Resident 3's 2/27/25 Nurse Practitioner Encounter Note revealed Resident 3 reported she/he had weakness to the right knee and leg. The resident was assessed to have generalized weakness due to deconditioning and had right sided weakness which was her/his baseline. Resident 3 was also assessed to have swelling in the legs and staff were to keep her/his legs elevated above the heart. Resident 3's 3/4/25 admission MDS revealed she/he was cognitively intact, had chronic pain, and a contracture to the right leg. Resident 3 was at risk for developing pressure ulcers due to diagnoses and medical conditions including diabetes, heart disease, kidney disease, peripheral vascular disease, and hemiparesis. Resident 3' 3/2025 Documentation Survey Report (CNA documentation) revealed on 3/20/25, 3/21/25, and 3/22/25 CNAs identified a red and discolored area, and the area was not new. The report indicated on day shift Resident 3 was independent to roll left to right on day shift 21 shifts and otherwise required moderate to substantial assistance, on evening shift 17 shifts she/he was independent, otherwise required contact assistance or more, and refused assistance on one shift. On night shift Resident 3 required contact assistance or more on 17 shifts, the activity was documented as not applicable on seven shifts, and she/he was independent on one shift. Resident 3's Progress Notes from 3/1/25 to 3/31/25 indicated she/he was independent with bed mobility but did not indicate her/his heels were elevated off the bed. There were no notes related to 3/20/25, 3/21/25, and 3/22/25 when a CNA identified skin issues on the Documentation Survey Report. Resident 3's 4/2025 Documentation Survey Report revealed Resident 3 required substantial to moderate assistance to roll in bed on most shifts. On evening shift there were 12 shifts when Resident 3 was independent, or the activity was not applicable. On night shift there were six shifts when the resident was independent, or the activity was not applicable. Resident 3's 5/7/25 Skin and Wound-Total Body Skin Assessment completed by Staff 28 (Wound Nurse) at 7:52 AM. The assessment indicated Resident 3 did not have any skin issues. Resident 3's 5/7/25 at 3:25 PM Progress Notes revealed a CNA found wounds on Resident 3's heels. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's 5/8/25 Skin and Wound Evaluation form revealed she/he had a facility acquired DTI (Deep Tissue Injury: purple or maroon localized area of discolored intact skin or blood˜filled blister due to damage of underlying soft tissue from pressure and/or shear. A DTI occurs in the tissue that has been subjected to pressures that exceed the tolerance level of muscle tissue. The muscle cell is deformed and irreversibly injured from the pressure) to the right heel. The DTI was 4.2 cm long and 1.8 cm wide, 100% covered with eschar (layer of dead tissue), had a moderate amount of drainage, and the edges were macerated (softened by drainage). Resident 3' 5/8/25 Skin and Wound evaluation form revealed Resident 3 had a facility acquired DTI to the left heel. The left heel DTI was 4.9 cm long and 2.5 cm wide, 100% covered with eschar, had a moderate amount of drainage and the edges were macerated. On 9/29/25 at 9:21 AM Staff 35 (CNA) stated when Resident 3 was initially admitted to the facility she/he was able to reposition in bed, but she/he could not put a pillow under her/his legs because she/he had leg weakness. Staff 35 stated Resident 3 did not refuse care, wore two different shoes, and the shoes were not tight. On 9/29/25 at 9:23 AM Staff 9 (LPN) stated when Resident 3 was first admitted to the facility she/he was able to move, but it was hard for her/him to move her/his legs. Resident 3 initially did not use pillows under her/his legs until after she/he developed pressure ulcers. Staff 9 stated Resident 3 did not refuse care, usually wore a black orthotic shoe and the shoe did not fit tight. If a CNA identified a skin issue, the CNA was to notify the nurse, the nurse was to assess the skin, make a progress note, notify the resident's medical provider, and provide care as needed. A skin sheet was initiated if it was a skin issue that needed to be monitored weekly, such as a pressure ulcer. On 9/29/25 at 3:28 PM Resident 3 stated she/he had bad circulation to her/his legs. Resident 3 stated she/he was not able to turn in bed independently and the staff did not provide pillows under her/his legs until she/he developed pressure ulcers. Resident 3 denied refusing to elevate her/his heels off the bed. On 9/29/25 at 4:13 PM Witness 8 (Spouse) stated Resident 3 had severe neuropathy (nerve damage which causes weakness, numbness, and pain usually in the hands and feet) and impaired circulation to her/his feet. The staff did not assist Resident 3 to turn, and she/he would not request assistance. On 9/30/25 at 10:32 Staff 34 (CNA) stated Resident 3 did not refuse care and she/he accepted a pillow under her/his leg to elevate heels off the bed. Staff 34 stated she recalled in 3/2025 Resident 3 had an area to the back of both heels and ankles which was red and purple and the skin was very flaky. Staff 34 also stated she notified a nurse. On 9/30/25 at 9;30 am Staff 7 (CNA) stated Resident 3 was assisted with repositioning and required extensive assistance. Resident 3 had pillows, but the pillows were not used very often until after the heel wounds developed. On 10/1/25 at 3:52 PM Staff 28 (Wound Nurse) stated she completed all the residents' weekly Total Body Skin Assessments. Staff 28 stated she reviewed the shower sheets to see if the CNAs reported any skin issues and also did a physical skin assessment on each resident. Staff 28 stated she completed Resident 3's 5/7/28 assessment in the morning of 5/7/25 and documented no skin issues and acknowledged the CNAs found the Resident 3's DTIs the same evening when they provided her/his shower. Staff 38 stated it was hard to say how long the DTI was there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/25 at 4:10 PM Staff 33 (Interim DNS) acknowledged Resident 3's Total Boday Assessment sheet completed the morning of 5/7/25 indicated she/he did not have any skin issues and approximately eight hours later had two DTIs with eschar. Staff 33 stated DTIs could develop very fast, but it was likely the DTIs were not identified in the am. Staff 33 also indicated there was no skin assessment in Resident 3's clinical record after the CNA identified skin issues on the 3/2025 Documentation Survey Report. 2. Resident 76 was admitted to the facility in 3/2025 with diagnoses including diabetes and stroke. A New Pressure Ulcer investigation dated 8/4/25 indicated Resident 76 was found with soiled dressing on the right heel. Upon removal, a 2 cm by 2 cm unstageable pressure ulcer (a wound with full-thickness tissue loss where the base is covered, making it impossible to determine the stage) was observed. No physician orders for the right heel wound were present in the medical record prior to 8/4/25. On 10/2/25 at 9:18 AM Staff 7 (CNA) stated during the end of 7/2025, she provided Resident 76 a shower and observed a skin tear on the right heel. Staff 7 reported the wound to the nurse. On 10/2/25 at 12:07 PM, Staff 1 (Administrator) confirmed there were no physician orders for Resident 76's right heel wound before 8/4/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure residents did not have cigarettes and lighters in their rooms and a fall investigation was thoroughly completed for 3 of 10 sampled residents (#1, 11, and 110) reviewed for accidents. This placed residents at risk for accidents. Findings include: 1. Resident 1 was admitted to the facility in 7/2024 with diagnoses including chronic obstructive pulmonary (lung) disease and epilepsy (brain disorder characterized by seizures). The 2/2025 facility Resident Smoking Policy and Procedure revealed ignition sources were not permitted in resident rooms. Lighters belonging to independent smokers were required to be stored in an assigned smoking locker. The 4/9/25 Nursing Smoking Screen revealed Resident 1 smoked more than 10 times daily and was able to light her/his own cigarettes. The 7/25/25 Annual MDS revealed Resident 1 had a BIMS of 15 (cognitively intact), used her/his wheelchair independently, and was a smoker. An 8/11/25 revised care plan directed staff to educate Resident 1 on the facility smoking policy, designated smoking locations, and safety concerns. On 9/29/25 at 12:26 PM, Resident 1 was observed in her/his room with a lighter in a plastic bag attached to her/his wheelchair and cigarettes in a dresser drawer. Resident 1 stated she/he was an independent smoker. On 9/30/25 at 12:06 PM and 2:00 PM, Resident 1 was observed to enter her/his room after being outside. Staff 19 (LPN) stated she thought Resident 1 quit smoking because the resident no longer returned smoking supplies to the resident's lock box at the front desk. On 9/30/25 at 12:13 PM, Staff 37 (CNA) stated she provided care to Resident 1 and did not believe the resident kept smoking supplies in her/his room because she was often seen at the front desk with the nurse. On 9/30/25 at 3:15 PM, Staff 30 (CNA) stated CNAs were hands-off with residents who were independent smokers and Staff 30 was unsure if independent smokers were required to store smoking supplies in a locked box. On 10/1/25 at 8:50 AM, Staff 36 (LPN) confirmed Resident 1 was in bed and had no smoking supplies in her/his lock box. Staff 36 stated she was unsure about the smoking policy for Resident 1 and the resident was not flagged to ensure smoking items were returned to the lock box. On 10/1/25 at 8:55 AM, Staff 14 (Unit Manager-LPN) stated no smoking materials were expected in Resident 1's room and acknowledged the resident was non-compliant with smoking rules. On 10/1/25 at 9:09 AM, Staff 1 (Administrator) acknowledged the facility needed to find a new (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	solution for the storage of Resident 1's lighter and smoking supplies. 2. Resident 11 was admitted to the facility in 4/2024 with diagnoses including stroke, respiratory infection, and respiratory failure. A 5/8/24 Nursing Restraint vs Enabler Screen identified Resident 11's bed canes were used for bed mobility. The 7/4/25 Quarterly MDS revealed Resident 11 had a BIMS assessment score of 14 (cognitively intact), the resident was on oxygen and had lower and upper impairment on one side. The 7/2025 TAR revealed Resident 11 required three liters of oxygen per minute via a nasal canula (plastic tubing in the nose), staff were to monitor the resident for shortness of breath and maintain oxygen saturation at or above 90%. A 7/15/25 revised care plan revealed Resident 11 required the assistance of two staff for transfers, she/he was at risk for falls, and interventions included bilateral bed canes, fall mats, and placement of her/his bed in the lowest position against the wall. An 8/30/25 Unwitnessed Fall investigation completed by Staff 13 (LPN) revealed, at approximately 2:45 PM, a CNA discovered Resident 11 on her/his knees with her/his face and upper body leaning on the bed. Resident 11 stated she/he attempted to get out of bed to assist a new roommate and appeared confused earlier in the day. No injuries were observed. Resident 11 was transported to the emergency room after unsuccessful attempts to return her/him to her/his wheelchair. The resident became difficult to rouse, and her/his oxygen saturation was at 59%. The report indicated predisposing factors of the fall included change in cognition, illness, and confusion about the new roommate. No additional information about the fall was found. On 9/30/25 at 5:15 PM, Staff 1 (Administrator) stated no issues were found based on the 8/30/25 fall investigation. Staff 1 expected staff to follow fall interventions according to the care plan. On 10/1/25 at 12:29 PM, Staff 13 stated staff did not know how Resident 11 fell and acknowledged a lack of documentation. Staff 13 confirmed she did not complete the required paperwork or request witness statements. On 10/1/25 at 1:42 PM, Staff 30 (CNA) stated Resident 11 was confused on 8/30/25 and was last observed in her/his room [ROOM NUMBER] minutes prior to the fall. Staff 30 did not recall the resident's bed being in the lowest position. On 10/1/25 at 3:44 PM, Staff 15 (CNA) stated she immediately assisted Resident 11 after the fall on 8/30/25. Staff 15 stated she found Resident 11 dangling from the bed with her/his head stuck between the bed and a bed cane. Staff 15 stated Resident 11's nasal canula was dislodged when the resident was found. Staff 15 confirmed her witness statement was not requested. On 12/2/25 at 4:34 PM, Staff 14 (Unit Manager-LPN) stated Resident 11 used her/his bed canes routinely for repositioning and a revised evaluation of the resident's bed canes was expected after her/his fall. Staff 14 acknowledged witness statements from all staff were not obtained as expected and the fall investigation was not thorough. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 110 was admitted to the facility in 9/2025 with a diagnosis of heart disease. A 2/2025 facility Resident Smoking Policy and Procedure revealed ignition sources of any kind were not to be kept by residents. Lighters belonging to independent smokers must be stored in their assigned smoking locker. Resident 110's 9/25/25 admission MDS revealed she/he was cognitively intact. Resident 110's Care Plan initiated on 9/26/25 revealed she/he was a supervised smoker. Resident 110 was to follow all the facility smoking rules. Staff were to instruct the resident on the facility smoking policy. On 9/29/25 at 11:25 AM Resident 110 was observed in bed with oxygen on, and she/he had cigarettes and a lighter on her/his bedside table. Resident 110 stated she/he took her/his oxygen off when she/he went out to smoke. On 10/1/25 at 9:09 AM Staff 1 (Administrator) stated lighters were not to be kept in the resident's room. On 12/3/25 at 8:51 AM Staff 27 (CNA) stated all residents were to keep cigarettes and lighters in a locked box even if they were independent smokers. Staff 27 stated she recalled 9/29/25 when Resident 110 had cigarettes and a lighter in her/his room and she removed them and put them in the locked box.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review it was determined that the facility failed to implement nutritional interventions to prevent weight loss for 1 of 4 sampled residents (#40) reviewed for nutrition. This placed residents at risk for continued weight loss. Findings include: Resident 40 was admitted to the facility in 6/2025 with a diagnosis of heart disease. a. Resident 40's 6/16/25 Nutritional Evaluation revealed the dietary manager was to evaluate Resident 40 for fortified food, if the resident would accept any of the typical offerings. Resident 40's clinical record revealed a diet order for fortified meals was initiated on 8/3/25. On 12/3/25 at 11:20 AM Staff 37 (District Dietary Manager) stated if a RD wrote orders for a fortified diet the dietary staff implemented the order. The RD would send an email to the dietary staff or would directly add the fortified meal into the resident's dietary orders. Staff 37 stated if a RD recommended a fortified diet but did not write an order, the dietary manager would not communicate with the resident, and the Resident Care Manager would need to obtain an order from a resident's physician. On 12/2/25 at 3:07 PM Staff 36 (LPN Resident Care Manager) stated he did not see communication to Resident 40's physician in 6/2025 related to a fortified diet and did not see a 6/2025 nutrition committee note related to adding fortified meals, and verified the fortified meals were not stared until 8/2025. b. Resident 40's 9/11/25 Nutrition Evaluation revealed she/he had weight loss and current interventions included two different supplemental drinks. Resident 40 was noted to refuse oral intake and there were concerns for depression. The recommendation was to consider starting mirtazapine (antidepressant which can also be an appetite stimulant). Resident 40's clinical record did not reveal staff communicated with Resident 40's medical provider if starting mirtazapine was an option to support weight gain. On 12/2/25 at 3:07 PM Staff 36 (LPN Resident Care Manager) stated when a recommendation by a RD was made to add a medication, staff communicated with a resident's physician. Staff 36 stated he did not see a note in Resident 40's record related to the RDs recommendation to add an antidepressant and did not see it in the nutrition committee notes. Staff 36 stated Resident 40 was depressed and losing weight. Staff 36 stated when Resident 40's medical provider met with her/him Resident 40 elected hospice services, but Staff 40 stated he did not see any notes related to weight loss or adding mirtazapine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on interview and record review it was determined the facility failed to provide sufficient respiratory services for 1 of 3 sampled residents (#11) reviewed for respiratory care. This placed residents at risk for unmet respiratory needs. Findings include:Resident 11 was admitted to the facility in 4/2024 with diagnoses including stroke and respiratory failure. The 5/24/23 facility Transportation Agreement revealed all vehicles were to be staffed and equipped in accordance with the minimum requirements of federal, state, and local laws and regulations. The 7/4/25 Quarterly MDS revealed Resident 11 required oxygen therapy. The 7/2025 TAR indicated Resident 11 required three liters of oxygen per minute via a nasal canula (a plastic tubing in the nose), staff were to monitor the resident for shortness of breath and maintain oxygen saturation (the amount of oxygen traveling through the blood) at or above 90%. A 7/2/25 signed Transportation Request Form indicated Resident 11 had appointments for labs and imaging on 7/7/25, she/he required a companion, and yes was marked for oxygen. On 9/29/25 at 3:24 PM, Witness 5 (Family Member) stated Resident 11 went to appointments without sufficient oxygen on 7/7/25 and emergency oxygen was needed. On 12/1/25 at 12:57 PM, Staff 16 (CNA) stated she accompanied Resident 11 to appointments on 7/7/25 and only one tank of oxygen was available. Staff 16 stated a new appointment was added during the trip and the transportation company did not have additional oxygen in the vehicle. Staff 16 stated Resident 11 was at an imagining appointment when her/his oxygen tank was nearly depleted. Staff 16 stated she felt unprepared for Resident 11's trip and contacted multiple facility staff to obtain emergency oxygen. On 12/1/25 at 1:32 PM, Staff 17 (Receptionist) stated nurses were responsible to assess oxygen needs prior to resident transport. Staff 17 stated she assumed all nurses were aware the transportation company did not carry emergency oxygen for appointments. On 12/1/25 at 1:47 PM, Staff 9 (LPN) stated he recalled the situation with Resident 11's oxygen and acknowledged he did not calculate a contingency for additional oxygen supply for residents who were transported to appointments. On 12/2/25 at 4:30 PM, Staff 13 (LPN) indicated she completed the form for Resident 11's appointment on 7/2/25 but was not present when Resident 11 left for the appointment on 7/7/25. Staff 13 was unaware the transportation company did not carry additional oxygen, and the Transportation Request Forms requirements were unclear. On 12/2/25 at 4:34 PM, Staff 14 (Unit Manager-LPN) expected nurses to calculate oxygen needs of residents during trips to the best of their ability. Staff 14 acknowledged she was unaware the transportation company did not carry additional oxygen and options for supplemental oxygen during trips were needed. On 12/3/25 at 9:03 AM, Witness 4 (Transportation Contract Manager) stated the facility was contacted due to concerns about residents' lack of oxygen during transport and acknowledged the contract required clarification regarding oxygen availability. On 12/3/25 at 1:56 PM, Staff 2 (DNS) acknowledged clearer expectations were needed regarding resident needs during appointments, including oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview, and record review it was determined the facility failed to ensure behavior health services were provided for 3 of 5 sampled residents (#s 9, 19, and 36) reviewed for behavioral-emotional health and hospice. This placed residents at risk for unresolved emotional needs. Findings include:1. Resident 9 was admitted to the facility in 4/2025 with a diagnosis of kidney disease. Resident 9's 8/13/25 Quarterly MDS revealed she/he was moderately cognitively impaired. Resident 9's 8/19/25 Initial Assessment by Witness 7 (Psychologist) revealed Resident 9 had anxiety, memory issues, fear of relocation, and had thoughts of embarrassment due to her/his current health and living situation. Resident 9 denied depression but alluded to the presence of depression. Witness 7 indicated Resident 9's behavioral health needs included emotional support and anxiety management. The plan included a referral to psychiatry to manage medication, low dose antianxiety medications, and regular therapy. Resident 9's clinical record did not reveal a referral to psychiatry or therapy notes. On 9/29/25 at 1:54 PM Resident 9 stated she/he was always depressed, was observed to be tearful during the interview, and stated she/he felt hopeless. Resident 9's 11/20/25 Significant Change MDS revealed Resident 9 was cognitively intact. On 12/2/25 at 11:46 AM Staff 18 (Social Service Director) stated Witness 7's contract was terminated in 9/2025 or 10/2025, and a new mental health provider did not start yet. Staff 18 stated Resident 9 was often tearful, sad, and was for a long time. On 12/3/25 at 10:29 AM Resident 9 stated it helped when she/he spoke to Witness 7. Resident 9 also stated she/he was able to address many issues but still had additional issues to resolve. Resident 9 stated it was really nice to have someone to talk with and to have someone listen. Resident 9 was observed to become tearful and stated, some things [she/] he can't get away from, and Witness 7 listened to her/him and helped her/him come to peace. On 12/3/25 at 1:48 PM Staff 1 (Administrator) stated a new mental health provider was to start in 10/2025, but the facility was notified they would not be available until 1/2026. Staff 1 stated there was no interim plan in place for behavioral health services. 2. Resident 19 was admitted to the facility and 12/2018 with diagnoses including depression, mood disturbances and suicidal ideations. The 12/11/18 Preadmission Screening and Resident Review (PASARR) Level 1 revealed Resident 19 exhibited indicators of severe mental illness. No documentation was found in Resident 19's clinical record to indicate the facility followed up with the mental health referral or requested a Preadmission Screening Review (PASRR) Level II evaluation. A 12/14/18 care plan indicated Resident 19 had psychosocial well-being concerns, a history of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suicidal ideations and needed long term care. The facility was to provide counseling by mental health services. The 4/14/23 Suicidal Precautions Checklist revealed Resident 19 made suicidal statements and reported feeling depressed and worthless. Resident 19 was to continue mental health provider services as needed for ongoing assessment and treatment for depression. A 5/5/23 Psych Consultant note recommended Resident 19 continue mental health provider services for ongoing assessment and treatment for depression. No documentation was found in the clinical record to indicate the facility followed up with the above recommendations. A 4/1/25 Psych Consultant note revealed Resident 19 reported having a rough couple of months due to family and personal challenges. Resident 19 expressed feeling lonely, isolated, and had difficulty in maintaining social connections. Resident 19 disclosed feeling depressed and stated her/his current antidepressants don't' seem to be working. Resident 19 noted experiencing suicidal thoughts and described methods she/he had considered, such as using something sharp to self-harm. Resident 19 stated I wanna end it, but I'm not brave enough. The assessment revealed Resident 19 presented with significant depressive symptoms including feelings of hopelessness, sadness, lack of motivation, and passive suicidal ideation. Resident 19's suicidal ideation and depressive symptoms pose a significant risk and warrant close monitoring. Resident 19 reported disconnection from her/his care team and lack of involvement. Staff were to immediately conduct a risk assessment for suicidal ideations and develop a crisis plan. Staff were to refer Resident 19 for psychiatric care and continue to provide regular psychotherapy. Staff were to follow up within one week to assess progress with referrals, ongoing depressive symptoms, and safety concerns. No documentation was found and the clinical record to indicate the facility followed up with the above recommendations. The 7/1/25 Quarterly MDS indicated Resident 19 was cognitively intact. An 8/5/25 Psych Consultant note revealed Resident 19 reported worsening depression with significant hopelessness and passive suicidal ideations. Resident 19 expressed profound isolation and despair. Resident 19's symptoms had worsened compared to the prior session, with escalating despair and more intense thoughts of self-harm. Resident 19 denies active suicidal plans but does endorse ongoing passive ideations; suicide risk remained elevated. Staff were to discuss the resident's case and advocate for evaluation for alternate placement and options to address unmet needs. No documentation was found in the clinical record to indicate the facility followed up with the above recommendations. On 9/29/25 at 5:38 PM, Resident 19 talked about her/his life situation. Resident 19's mood fluctuated throughout the interview as she/he spoke about these concerns. Resident 19 admitted to having thoughts of self-harm, including wanting to cut her/his legs off. Resident 19 stated a while ago she/he was seen by a counselor but did not know why they had not returned. Resident 19 stated they would like to see a professional counselor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/25 at 8:37 AM, Staff 38 (CNA) stated Resident 19 fixated on her/his past life, which caused her/his significant depression. Resident 19 had a history of self-sabotage and often punished herself/himself by intentionally urinating on herself/himself and refusing to eat. On 12/1/25 at 10:53 AM, Staff 39 (CNA) stated Resident 19 had been more depressed since August. Staff 39 stated at that time, the resident's antidepression medications was increased, and to her knowledge, this was the last time the resident received counseling. Staff 39 stated Resident 19 had a history of expressing suicidal ideations. Staff 39 stated Resident 19 recently talked about driving her/his motorized wheelchair over the overpass to jump off. Staff 39 stated when Resident 19's depression worsened she/he would stop caring for herself/himself. Staff 39 further stated Resident 19's moods frequently fluctuated, and she/he was difficult to redirect. On 12/2/25 at 9:23 AM, Staff 40 (Social Service Assistant) stated Resident 19's depression had recently increased. Staff 40 confirmed Resident 19's family recently voiced concerns about her/his worsening depression and behaviors but she did not follow up. Staff 40 reported the facility recently ended their contract with the previous behavioral health provider and confirmed, for the past several months, Resident 19 had not been receiving treatment for her/his behavioral health needs. On 12/2/25 at 11:23 AM, Staff 18 (Social Worker) stated Resident 19's behaviors fluctuated, and she/he had a history of suicidal ideations. Resident 19 was receiving behavioral health services until the facility ended their contract several months ago and she did not know when the facility was going get a new behavioral health provider. Staff 18 stated she was not aware of Resident 19's family concerns about her/his increased depression or request for behavioral health services. Additionally, Staff 18 stated about a year ago she completed a PASRR audit, but resident 19 was not included. Staff 18 confirmed Resident 19's PASRR Level I indicated SMI indicators, but no follow-up was initiated. On 12/2/25 at 3:15 PM, Staff 20 (Unit Manager/LPN) stated she was familiar with Resident 19's psychiatric history and behaviors. Staff 20 reported Resident 19's depression fluctuated but typically worsened during the holidays. Staff 20 stated the resident had been seen by behavioral health services a few months ago, but the facility did not have a behavioral health provider at this time. Staff 20 further stated she was not aware of Resident 19's family's concerns regarding the resident's increased depression or their request for behavioral health services. On 12/2/25 at 3:10 PM, Staff 1 (Administrator) confirmed the facility had not followed up on physician recommendations for behavioral health services and the facility would not have a behavioral health provider until 1/2026. On 12/3/25 at 10:15 PM, Witness 9 stated Resident 19's antidepressant medication had been increased, but it did not appear to be effective. Witness 9 expressed concerns about her/his self-harming behaviors. Witness 9 stated Resident 19's depression often worsened during the holidays, leaving her/him feeling hopeless and helpless. Witness 9 stated Resident 19 would benefit from counseling services to help her/him learn coping strategies. Witness 9 further stated she notified the facility of her concerns and requested behavioral health services, including counseling, but the facility had not responded. 3. Resident 36 admitted to the facility and 2/2025 with diagnosis including encephalopathy (disease of the brain that changes its function). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/4/25 care plan indicated Resident 36 had a history of trauma related to physical abuse. Resident 36 was to maintain optimal quality of life despite a history of trauma. Resident 36 was unaware of the specific situations that caused her/him stress or feelings of being overwhelmed and she/he relied on staff support. A 6/10/25 Provider Note revealed Resident 36 exhibited symptoms of anxiety and paranoia, hearing external threats regarding her/his finances and personal safety. Resident 36 showed signs of mild cognitive impairment. Staff to consider a psychiatric evaluation to assess the resident's paranoia and possible delusional thinking. Diagnoses include delusional disorder and generalized anxiety. On 9/30/25 at 1:00 PM, an interview was attempted with Resident 36, however the resident appeared frightened, avoided eye contact, and responded with nonsensical statements. A 10/19/25 Progress Note revealed staff notified Resident 36's physician regarding increased aggression during exit seeking behavior. The physician's response directed staff to have Psych follow up with Resident 36. On 12/2/25 at 1:30 PM, Staff 39 (CNA) and the surveyor approach resident 36 in her/his room. The resident appeared frightened and confused and began making statements staff were stealing her/his belongings. Staff 39 stated resident 36 often had difficult behaviors and was difficult to redirect. Staff 39 further stated she was not aware what type of behavioral health services the resident received. On 12/2/25 at 3:04 PM, Staff 20 (Unit Manager/LPN) stated she did not know what psych services the facility currently provided for Resident 36. On 12/2/25 at 3:10 PM, Staff 1 (Administrator) stated Resident 36 was a complex resident with a history of trauma. Staff 1 confirmed the facility had not followed up on the physician's recommendations for behavioral health services and the facility would not have a behavioral health provider until 1/2026.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385149	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland House Nursing & Rehabilitation Center	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)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on interview and record review it was determined the facility failed to ensure a resident received thickened liquids as ordered for 1 of 4 sampled residents (#40) reviewed for nutrition. This placed residents at risk for aspiration. Findings include: Resident 40 was admitted to the facility in 6/2025 with a diagnosis of heart disease. Resident 40's 9/16/21 Dietary Order Details revealed she/he was to receive mildly thickened liquids. Resident 40's 9/21/25 Progress Notes revealed Staff 29 (LPN) notified Residents 40's medical provider that she/he aspirated during a meal. Resident 40's provider ordered a chest x-ray. Resident 40's 9/21/25 communication form to Resident 40's medical provider revealed she/he aspirated at lunch while drinking Ensure which was not thickened. The form included a handwritten note by Resident 40's medical provider dated 9/23/25 which revealed Resident 40's chest x-ray was negative. On 10/1/25 at 7:19 AM Staff 29 verified a CNA provided Resident 40 a supplemental drink which was not thickened, Resident 40 aspirated, and she notified her/his physician. On 12/2/25 at 7:09 PM Staff 14 (LPN Resident Care Manager) stated the supplemental drinks such as Ensure were to be thickened by a nurse, CMA, or dietary staff if a resident was on a thickened liquid diet.