STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385167	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hills Rehabilitation Center	1166 E. 28th Avenue Eugene, OR 97403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on interview and record review it was determined the facility failed to protect residents' right to be free from verbal abuse by staff for 1 of 3 residents (#10) reviewed for abuse and neglect. This placed residents at risk for abuse. Findings include: Resident 10 admitted to the facility in 9/2024 with diagnoses including chronic ulcer to left lower leg, and fracture to the sacrum. An Investigation Report, with an investigation date from 10/3/24 through 10/8/24, revealed on 10/3/24 at approximately 11:00 AM Resident 10 asked Staff 17 (Admissions Coordinator) to assist with filling out a grievance form. Resident 10 stated she/he was asleep and Staff 4 (CNA) came into the room and, with a loud voice, stated I need your vitals. Staff 4 was loud enough to wake Resident 10 from a deep sleep. Resident 10 stated she/he did not know why Staff 4 was yelling. Staff 4 continued to yell and his voice got louder. Resident 10 stated she/he raised her/his voice to match Staff 4's voice. Staff 4 informed Resident 10 he was at the facility for three years and stated he was going to do what he does. Staff 4 left the room, and then came back and told Resident 10 to turn the TV down because it was too loud, and then he left. Staff 4 came back a third time and yelled I'm going to do what I have to do. Resident 4 stopped talking and listening to Staff 4 because his voice was too loud. Staff 4 came back into the room again and stated, It does not matter what you say to anyone, I'm going to do what I want to do. Resident 10 repeated what Staff 4 said, and Staff 4 started calling Resident 10 a [NAME]. Staff 4 called Resident 10 a liar multiple times with each time getting louder. Resident 10 asked Staff 4 to leave the room multiple times, but he continued to stay and call Resident 10 a liar. A 10/7/24 MDS indicated Resident 10's BIMS score was 15 indicating she/he was cognitively intact. Resident 10 exhibited no physical, verbal, or other behavioral symptoms during the seven days look back period. (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 10:56 AM Resident 10 stated Staff 4 called her/him a damn liar six to eight times. Resident 10 stated Staff 4's voice was strong and when Staff 4 came into the room he just slapped the blood pressure cuff on her/him while she/he was still in a daze from waking up. Staff 4 told Resident 10 he needed to get the vitals checks completed. Staff 4 told Resident 10 he was so loud because his roommate was hard of hearing. Staff 4 came back into the room later and told Resident 10 to turn down her/his TV. Resident 10 stated she/he felt like Staff 4 verbally abused her/him. Resident 10 stated she/he told Staff 4 to leave her/his room six to eight times. Resident 10 stated Staff 32 could also hear what occurred. On 10/14/24 at 10:58 AM Staff 17 stated on 10/3/24 she went into Resident 10's room and she/he reported Staff 4 verbally abused her/him. Resident 10 requested to speak to the Staff 1 (Administrator) or Staff 2 (DNS) and if they were not available to fill out a grievance. Staff 17 did not find Staff 1 or Staff 2 so as she brought back a grievance form to Resident 10's room, she could hear yelling down the hallway coming from Resident 10's area. When Staff 17 arrived at Resident 10's door Staff 4 was at the foot of Resident 10's bed, and Staff 32 (LPN) was standing by the closets in the room. Staff 4 was apologizing to Resident 10, Resident 10 interrupted Staff 4 and asked him to get out of her/his room. As Staff 4 walked out of the room he stopped three different times and yelled at Resident 10 she/he was a [NAME]. After Staff 4 left the room Staff 32 informed Resident 10 she would replace Staff 4 with another CNA. Attempts to contact Staff 32 on 10/11/24, 10/14/24 and 10/15/24 by phone were unsuccessful. On 10/15/24 at 8:43 AM Staff 4 stated he went into Resident 10's room, obtained her/his vital signs, and she/he was upset about Staff 4 waking her/him up. Staff 4 then went to obtain Resident 10's roommate's vital signs, it was bothering Resident 10, and she/he asked Do you have to be so fucking loud? Staff 4 brought Resident 10 breakfast and later she/he stated Staff 4 did not bring her/his breakfast. Staff 4 came back to the room to apologize and stated to Resident 10 they did not have a good start to the day, but Resident 10 was still upset. Staff 4 stated he did call Resident 10 a liar but did not yell at her/him. On 10/16/24 at 10:30 AM Staff 1, Staff 2 and Staff 37 (Regional Nurse Consultant) stated during their investigation Staff 17 did not say Staff 4 was yelling at Resident 10. Staff 2 confirmed their investigation was found to be unsubstantiated. Staff 2 stated Staff 4 should have left Resident 10's room and reported Resident 10's behavior to a charge nurse when Resident 10's behavior escalated and she/he told Staff 4 to leave the room.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35855 Based on interview and record review it was determined the facility failed to report investigations timely to the State Survey Agency for 3 of 6 sampled residents (#s 12, 19, and 20) reviewed for medications, abuse, and neglect. This placed residents at risk for abuse and neglect. Findings include: 1. Resident 12 admitted to the facility in 9/2024 with diagnoses including anxiety and a leg fracture. A FRI form dated 9/22/24 indicated an incident was reported to the State Agency on 9/22/24 for an unknown incident date. A related Investigation Report with an investigation date of 9/22/24 through 9/27/24 was received by the State Agency on 10/2/24. On 10/16/24 at 10:49 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated Staff 2 thought she emailed the investigation timely, but she did not, and confirmed the investigation was sent late to State Agency. 2. Resident 19 admitted to the facility in 5/2024 with diagnoses including pain and surgical aftercare. A FRI form dated 6/24/24 indicated an incident was reported to the State Agency on 6/24/24 for a 6/19/24 incident. The facility was made aware of the incident on 6/24/24. An Investigation Report with an investigation date of 6/19/24 through 7/1/24 was received by the State Agency on 7/4/24. On 10/16/24 at 10:58 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated the facility had issues contacting one of the witnesses and confirmed the investigation was sent late to the State Agency. 3. Resident 20 admitted to the facility in 5/2024 with diagnoses including a leg fracture. A FRI form dated 9/27/24 indicated an incident was reported to the State Agency on 9/27/24 for a 9/27/24 incident. The facility was made aware of the incident on 9/27/24. An Investigation Report with an investigation date of 9/27/24 through 10/10/24 was received by the State Agency on 10/10/24. On 10/16/24 at 11:27 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) confirmed the 9/27/24 investigation was sent late to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 35855 Based on interview and record review it was determined the facility failed to conduct timely or thorough investigations for 3 of 6 sampled residents (#s 11, 19, and 20) reviewed for medications and accidents. This placed residents at risk for falls, uncontrolled pain, and overdose. Findings include: 1. Resident 11 admitted to the facility in 3/2023 with diagnoses including arthritis. Review of a Progress Note dated 6/3/24 revealed Resident 11 was found on the floor next to her/his bed laying on her/his left side. A review of an Un-witnessed Fall investigation dated 6/3/24 revealed Resident 11 was found on the floor next to her/his bed laying on her/his left side. The investigation was completed on 6/26/24. On 10/16/24 at 10:39 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) confirmed Resident 11's fall investigation for her/his 6/3/24 fall was completed late. 2. Resident 19 admitted to the facility in 5/2024 with diagnoses including pain and surgical aftercare. A review of the TAR dated 6/2024 instructed staff to change Resident 19's right lower leg dressing daily with a start date of 5/28/24. On 6/19/24 and 6/21/24 Staff 18 (Agency LPN) completed Resident 19's wound treatment. An Investigation Report with an investigation date of 6/24/24 through 7/1/24 indicated Resident 19 submitted a grievance on 6/24/24 alleging Staff 18 (Agency LPN) was rough during care and had poor bedside manner during wound care treatment on 6/19/24. Resident 19 indicated the application of skin prep was more sensitive and caught [her/him] off guard. Staff 18 was taken off the facility's schedule and would not be rescheduled. Allegations of mistreatment and abuse were unsubstantiated. The investigation did not include witness statements of other residents, staff, or Staff 18. Attempts to reach Resident 19 on 10/8/24 and 10/9/24 were unsuccessful. On 10/14/24 at 10:21 AM Staff 18 stated the facility did not contact her regarding the concern about Resident 19's wound care and she was unaware there was a concern. On 10/16/24 at 11:03 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) confirmed the investigation should have included information about Resident 19's pain medication. Staff 2 stated they were unable to contact Staff 18 for a witness statement. Staff 2 stated she was out of the facility and may not have followed up after her return. 3. Resident 20 admitted to the facility in 5/2024 with diagnoses including a leg fracture. A review of a Nursing Note dated 9/27/24 indicated Resident 20 was unresponsive roughly an hour after a medication administration. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Investigation Report with an investigation date of 9/27/24 through 10/10/24 revealed Resident 20's family member reported the facility was sedating and abusing Resident 20. On 9/22/24 a floor nurse reported altered mentation of the resident, Resident 20 was examined at a hospital emergency department (ED), and then returned to the facility. Resident 20 complained of inadequate pain control and repeatedly requested more narcotic pain and sedating medications. There was discussion of narcotic influence as the longer she/he was in the ED the normal she/he presented. The physician indicated it was suspected Resident 20 had altered mentation due to sedation from pain medications. The conclusion of the investigation revealed abuse and neglect were ruled out, Resident 20 had altered mentation on 9/27/24 and the facility responded timely. Per provider and family direction the facility was to assist the resident to balance and manage pain with pain medications, but not over-sedate the resident. The investigation included a paragraph regarding a different resident and a verbal altercation with another resident unrelated to Resident 20's investigation. The investigation did not include a reconciliation of Resident 20's medications or review of administration of narcotics or sedating medications administered. On 10/14/24 at 9:53 AM Staff 26 (LPN) stated on 9/27/24 Resident 20 was completely cognitively intact and, after medication administration, Resident 20 was unresponsive and she/he was sent to the ED. On 10/16/24 at 11:28 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated they were focusing on the general complaint and communication between the facility and the emergency room visits. Staff 37 stated she reviewed medications to ensure administered as ordered but did not include in the investigation. Refer to F842.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 35855 Based on interview and record review it was determined facility staff failed to follow professional standards of practice during care and services for 1 of 3 (#12) sampled residents reviewed for abuse and neglect. This placed residents at risk for abuse and neglect. Findings include: Resident 12 admitted to the facility in 9/2024 with diagnoses including a leg fracture. A FRI was received on 9/23/24 which indicated Staff 7 (CNA) was a little too personal with her. Staff 7 spent too much time with Resident 12, rubbed cream on her/his buttocks and massaged her/his right hip in a way which felt inappropriate, and unlike any other staff. Staff 7 also gave Resident 12 a big hug. Staff 7 provided his personal phone number to Resident 12 and reported to her/him that he could be her/his personal caregiver at her/his home when she/he discharged from the facility. Staff 7 also spent way too much time with Resident 12 and came into her/his room and visited with her/him. On 10/8/24 at 12:58 PM Resident 12 stated Staff 7 massaged her/his leg, and no other CNAs were massaging her/him. Staff 7 came and sat in Resident 12's room for a long time and when he left, he asked Resident 12 for a hug as he told her/him he was not coming back. Resident 12 stated she/he felt Staff 7 was going over the line. Staff 7 also provided his name, address, and phone number to be a possible in-home caregiver after she/he discharged from the facility. Resident 12 stated she/he did not feel it was sexual abuse but felt Staff 7's behavior was not professional. On 10/11/24 at 8:17 AM Witness 7 (Family Member) stated Resident 12 reported to her that Staff 7 was overly friendly and wrote his name and phone number on paper to be Resident 12's home caregiver. Witness 7 stated Staff 36 (Speech Therapist) took a photo of the paper. Staff 7 also took a tube of cream out of her/his pocket and told Resident 12 it was a cream he used on her/his bad back, and he applied the cream on Resident 12. Witness 7 stated Resident 12 never complained of any of the other staff members and she/he no longer wanted Staff 7 to provide care to her/him. On 10/11/24 at 9:25 AM Staff 36 stated she saw the paper with Staff 7's contact information he provided to Resident 12, and she photographed the paper and reported the information to Staff 35 (Director of Rehabilitation). On 10/11/24 at 9:41 AM Staff 35 stated he reported the information from Staff 36 regarding Staff 7's contact information to Staff 1 (Administrator) as he was told it was inappropriate. Staff 35 stated it was in their hands after he reported it. On 10/11/24 at 11:41 AM Staff 7 stated he provided his phone number to Resident 12's family for possible in-home caregiving. Staff 7 stated he did not sit with Resident 12 and visit with her/him in her/his room. Staff 7 stated he believed Resident 12 gave him a hug once as a friendly thank you type hug. Staff 7 denied massaging Resident 12's hip but did provide incontinent care and barrier cream. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:43 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) confirmed it was against facility policy and a conflict of interest for Staff 7 to provide his phone number and solicit work outside of the facility to Resident 12, and Resident 12 was modest but did not feel inappropriate physical contact occurred. Resident 12 reported that conversations between Staff 7 and Resident 12 were odd.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on interview and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 2 of 3 sampled residents (#s 21 and 22) reviewed for ADLs. This placed residents at risk for unmet needs. Findings include: 1. Resident 21 admitted to the facility in 8/2024 with diagnoses including dementia and anxiety. A review of Resident 21's care plan dated 8/20/24 indicated Resident 21 had an ADL self-care performance deficit and required substantial to maximal assistance from staff with bathing. The admission MDS dated [DATE] revealed Resident 21's BIMS score was four, which indicated severe cognitive impairment. A review of the Documentation Survey Report (DSR) for 8/20/24 through 8/31/24 revealed Resident 21's bathing days were Monday and Thursday, and she/he required substantial to maximal assistance from staff for bathing on 8/22/24. On 8/26/24 there was no documentation Resident 21 received bathing. On 8/29/24 documentation indicated Resident 21 refused bathing. The DSR from 9/1/24 through 9/16/24 revealed Resident 21 received bathing on 9/5/24, and refused bathing on 9/2/24 and 9/12/24. On 9/9/24 Staff 19 (CNA) documented bathing was not attempted due to environmental limitations. Resident 21 went 13 days without bathing from 8/23/24 to 9/5/24, and seven days from 9/6/24 through 9/16/24. A review of 8/2024 and 9/2024 Skin and Shower Review sheets revealed on 8/26/24 a sheet was filled out with no resident signature of refusal and was signed by a CNA and nurse. No other information was on the form. On 8/28/24 the sheet was signed by Resident 21 as refused bathing and signed by the CNA and nurse. No other documentation of Skin and Shower Review sheets were found in Resident 21's clinical record. On 10/10/24 at 12:18 PM Staff 19 stated he only worked at the facility for a few weeks and did not know to mark environmental issues instead of resident refusal when there was a lack of staff, and he could not complete Resident 21's bathing. On 10/14/24 at 9:20 AM Staff 27 (CNA) stated the process when a resident refused a shower was to reapproach the resident, complete a Skin and Shower Review sheet, have the resident sign the sheet that she/he refused the shower, and then the nurse would also sign the sheet. On 10/16/24 at 11:29 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated they were starting a new tracking system for missed showers. 2. Resident 22 admitted to the facility in 7/2024 with diagnoses including history of falling, dementia, and anxiety. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 the State Survey Agency received a public complaint which indicated Resident 22 had an incontinent episode because it took staff longer to assist residents as the facility was short-staffed. A review of Resident 22's care plan dated 7/22/24 indicated she/he had an ADL self-care performance deficit and was totally dependent on one staff for toilet use and transferring. Resident 22 had occasional bladder incontinence and used a bedside commode. The Admission MDS dated [DATE] revealed Resident 22 was rarely understood, required substantial to maximal assistance with toilet transfers and was occasionally incontinent of bladder. A Direct Care Staffing Daily Report revealed on 8/2024 during the evening shift Resident 22 was continent 22 times out of 31 opportunities. On 8/13/24 there was no documentation of bladder elimination. There were five instances Resident 22 was documented as wet and one time as soaked. A Direct Care Staff Daily Report dated 8/28/24 revealed on evening shift the facility was not staffed to meet the state minimum staffing requirements. On 10/9/24 at 9:59 AM Witness 4 (Complainant) confirmed Resident 22 had an incontinent episode due to a long wait for staff assistance. On 10/8/24 at 10:36 AM Staff 28 stated there were negative outcomes to the residents because the facility was short-staffed including continent residents experiencing incontinent episodes. On 10/16/24 at 11:32 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated staff were supposed to call Staff 2 even if it was the middle of the night if they needed assistance because of low staffing.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35855 Based on observation, interview, and record review it was determined the facility failed to provide sufficient staffing to meet the needs of residents for 3 of 5 sampled residents (#14, 17, and 22) and 2 of 2 floors (1st floor and 2nd floor) reviewed for staffing. This placed residents at risk for unmet needs. Findings include: 1. Resident 17 admitted to the facility in 4/2024 with diagnoses including paraplegia and pressure ulcer. A review of Resident 17's care plan dated 4/16/24 indicated Resident 17 was at risk for falls and to ensure the resident's call light was in reach, to encourage the resident to use it for assistance, and she/he needed prompt response to all requests for assistance. A review of Resident 17's admission MDS dated [DATE] revealed Resident 17's BIMS score was 15 which indicated she/he was cognitively intact. On 10/8/24 at 10:10 AM Resident 17 stated the facility was short-staffed in 8/2024 and 9/2024 and there were times when here/his call light was activated for multiple hours without response. Weekends were horrible with one CNA to 45 residents. On 10/8/24 at 10:36 AM Witness 3 (Complainant) stated she quit working at the facility because the short staffing was unsafe for the residents. Every weekend was short-staffed. One weekend she was assigned 23 residents on day shift. Witness 3 stated residents did not receive showers, and there were incontinent episodes for residents who were continent as well as many falls. On 10/15/24 at 8:41 AM Staff 4 (CNA) stated when he took breaks and lunches the other CNAs did not answer his call lights and, as a result, residents had to wait. Staff 4 stated the short staffing at the facility was ridiculous. On 10/16/24 at 11:05 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated they worked with their corporate office to address the concern of staffing. 2. Resident 22 admitted to the facility in 7/2024 with diagnoses including history of falling, dementia and anxiety. On 8/28/24 the State Survey Agency received a public complaint which indicated Resident 22 had an incontinent episode because it took staff longer to assist residents as the facility was short-staffed. The Admission MDS dated [DATE] revealed Resident 22 was rarely understood, required substantial to maximal assistance with toilet transfers and was occasionally incontinent of bladder. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Direct Care Staffing Daily Report for 8/2024 revealed on evening shift Resident 22 was continent 22 times out of 31 opportunities. On 8/13/24 there was no documentation of bladder elimination. There were five instances Resident 22 was documented as wet and one time as soaked. A Direct Care Staff Daily Report dated 8/28/24 revealed on evening shift the facility was not staffed to meet the state minimum CNA staffing requirements. On 10/9/24 at 9:59 AM Witness 4 (Complainant) confirmed Resident 22 had an incontinent episode because she/he had to wait for staff assistance. On 10/16/24 at 11:05 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated they worked with their corporate office to address the concern of staffing. 3. On 10/8/24 at 10:36 AM Staff 28 stated there were negative outcomes to the residents because the facility was short-staffed including continent residents experiencing incontinent episodes. On 10/8/24 at 10:36 AM Staff 28 (CNA) stated the short staffing at the facility made it unsafe for the residents in 8/2024 and 9/2024. Every weekend the facility was short-staffed, and one day shift she was assigned 23 residents. Bathing was not completed, residents who were continent had incontinent episodes, and there were many falls. Some residents required one-to-one care and there was not enough staff to do so. On 10/11/24 at 8:54 AM Staff 5 (Agency CNA) stated in 8/2024 low staffing was an issue at the facility. One resident was non-weight-bearing, and she/he positioned her/his commode closer to the bed to try and self-transfer because staff could not get there to assist. Another resident did not receive wound care treatments as ordered and refused showers because she/he was concerned her/his wound would get wet and staff would not have time to change the dressing. Staff 5 stated she did not see the facility administration assist when the facility was short-staffed. On 10/11/24 at 11:26 AM Staff 15 (Former CNA) stated there was always a staffing issue at the facility. Staff 15 stated residents fell because of short staffing as it was difficult to keep eyes on everyone who was a fall risk. Staff 15 stated she did not always have time to complete showers and she quit her job at the facility because of the staffing issues. On 10/11/24 at 11:41 AM Staff 7 (CNA) stated it was very common for the facility to be short-staffed, and when he was not working, he received text messages every day during all shifts to come and assist. During one evening shift in 8/2024 he was assigned 24 residents, and he stated at times he did not have time to complete resident bathing and personal hygiene tasks. On 10/14/24 at 9:07 AM Staff 31 (CNA) stated the facility was short-staffed. Staff 31 stated she assigned to provide care for 22 residents and after working four days in a row had to take two days off because her back hurt so bad. Staff 31 stated the short staffing was causing burnout. When Staff 31 came to work there were instances when residents were soaked with urine as a result of deficits with the previous shift. Staff 31 stated some CNAs did their jobs and others reported to her that a resident was strange and those were instances where usually the CNA staff did not provide incontinent care. (continued on next page)

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	385167	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hills Rehabilitation Center	1166 E. 28th Avenue Eugene, OR 97403

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/14/24 at 9:20 AM Staff 27 (CNA) stated there were staffing concerns off and on, and on 10/13/24 one staff member worked for 24 hours straight, and then he came in and worked a 12 hour shift. Staff 27 stated it was a mess on day shift. Staff 27 stated he usually worked the first floor which was usually not fully staffed. Staff 27 stated, depending on who was working, there were long call light wait times. On 10/14/24 at 11:12 AM Staff 10 (Unit Manager) stated weekend staffing could be a challenge. During the Summer, short staffing on weekends was common and staff had to work harder than normal to complete needed assignments. On 10/15/24 at 8:13 AM Staff 3 (LPN) stated on 10/14/24 a nurse worked by herself for four hours and had two new resident admissions to the facility. There were assignments which were not completed on the previous shift that were passed on to her, and Staff 3 also had to assist in completing that work. Staff 3 stated the facility was almost always short-staffed of CNAs. On 10/15/24 at 9:06 AM Staff 38 (Agency CNA) stated when she first arrived at the facility, she received no orientation and had to ask many questions to know what to do. Staff 38 stated another agency staff provided her information. Staff 38 stated she attempted to complete charting on residents' care, but could not get into the electronic health record system. Staff 38 stated she could not access residents' care plans to know their care needs, and had to ask another temporary agency staff member to find out the care needs of the residents. On 10/15/24 at 9:11 AM Staff 39 (CNA) stated the facility was short-staffed and CNAs responded to call lights the best they could. Staff 39 stated recently on day shift she was assigned 16 to 17 residents. On 10/16/24 at 7:54 AM Staff 30 (Former LPN) stated she quit working at the facility because of low staffing levels. The facility could not keep staff and most of the CNAs were agency staff. There were concerns of residents falling because of low staffing. The CNAs between the first floor and the second floor were not always assigned residents according to State required minimum stafing levels; one CNA may have less than the maximum number of residents, and another more. On 10/16/24 at 8:18 AM Resident 25 confirmed she/he attended an 8/23/24 resident council meeting. Resident 25 was surprised no mention of staffing concerns were documented on the resident council minutes. Resident 25 stated the facility lost the staffing coordinator and on 10/15/24 during the night there was not enough staff in the facility. On 10/16/24 at 8:22 AM Resident 26 confirmed she/he attended an 8/23/24 resident council meeting and thought the reason staffing was not mentioned during resident council meeting was because there was nothing which could be done to solve it, so it did not do any good to mention the staffing concerns during the meeting. On 10/16/24 at 9:15 AM Staff 41 (Former Unit Manager) stated she worked with residents many times to cover for nurses who did not show up to work or called off of work. Staff 41 stated the facility was consistently short one to two CNAs. Call light wait times for residents were over 30 minutes, and resident had falls because there were not enough staff to supervise residents who were impulsive and were fall risks. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 11:05 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated they worked with their corporate office to address the concern of staffing.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 35855 Based on observation, interview, and record review it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for staffing. This placed residents at risk for incomplete and inaccurate staffing information. Findings include: A review of the Direct Care Staff Daily Reports (DCSDR) from 7/1/24 through 7/30/24, and 8/1/24 through 8/31/24 revealed the following: -7/3/24 no census documented on evening and night shift. -7/7/24 no census documented on night shift. -7/8/24 no DCSDR completed. -7/17/24 no hours worked documented for CNAs on day shift. -7/18/24 no DCSDR completed. -7/21/24 no census documented on night shift -8/10/24 no census documented on night shift -8/23/24 day shift census documented as 27, evening shift documented as 29 and night shift documented as 74. (8/22/24 census was 74 on day shift and 73 on evening and night shift.) A review of Daily Punches (staff time sheet) dated 8/15/24 and 8/28/24 revealed the following: -8/15/24 evening shift: four CNA staff worked a total of 32.5 hours, plus one CNA worked two hours and another CNA worked five hours for a grand total of 39.5 hours worked across six CNA staff. -8/28/24 evening shift: five CNA staff worked a total of 40 hours, plus one CNA worked one hour for a grand total of 41 hours worked across six CNA staff. Review of the DCSDRs for evening shift dated 8/15/24 and 8/28/24 revealed the following: -8/15/24 evening shift: seven CNA staff worked with a total of 56 hours worked. -8/28/24 evening shift: six and a half CNA staff worked with total of 52 hours. On 10/8/24 at 8:37 AM the DCSDR was observed on the wall which all three shifts for 10/7/24 were documented and the 10/8/24 DCSDR was not posted. On 10/9/24 at 10:39 AM and 11:04 AM the DCSDR was observed on the wall which had the day shift staff and hours worked but no census was documented. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 11:08 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated the facility had new nurses in general and additional education on completion of the DCSDR sheets was needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35855 Based on interview and record review it was determined the facility failed to ensure resident records related to controlled medications were complete and accurate for 1 of 3 sampled residents (#20) reviewed for medications. This placed residents at risk for medication errors. Findings include: Resident 20 admitted to the facility in 5/2024 with diagnoses including a leg fracture. Review of the 9/2024 Narcotic Logbook (NLB) revealed the following regarding oxycodone (narcotic pain medication) related to Resident 20: Oxycodone five mg one tablet twice daily PRN start date 9/18/24: -9/20/24 4:30 AM one tablet, 8:13 AM two tablets, and 8:45 PM two tablets. -9/21/24 2:15 AM two tablets, 7:07 AM one two tablets, 1:30 PM two tablets, 4:19 PM one tablet, 8:45 PM two tablets. -9/22/24 7:05 AM two tablets 9/27 (under 9/22/24) 8:30 PM two tablets. -9/23/24 7:19 AM one tablet, 1:04 PM one tablet, and 8:35 PM two tablets. -9/24/24 9:34 AM one tablet, 1:19 PM two tablets, and 7:30 PM one tablet. Resident 20 was administered two tablets instead of one on nine occurrences and was administered over the twice a day order on four days. Oxycodone five mg one tablet every four to six hours start date 9/17/24: -9/17/24 7:26 PM two tablets -9/18/24 12:00 AM, one tablet 8:45 AM, 3:02 PM one tablet, 8:00 PM was documented three times on lines 5, 6, and 7 with one tablet documented on each line (one wasted so two total administered). -9/19/24 12:36 AM one tablet, 3:00 PM one tablet, Line 11 time was illegible with one tablet administered and quantity going from two tablets to zero tablets. Resident 20 was administered two tablets instead of one physician ordered tablet two occurrences. Oxycodone one tablet every six hours not to exceed three tablets in a day start date 9/7/24: -9/10/24 2:09 AM one tablet -9/12/24 12:08 AM one tablet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9/14/24 4:16 PM one tablet, 10:25 PM one tablet, 9/14/24 5:45 AM (next line under the 10:25 PM administration) one tablet. -9/19/24 8:00 PM one tablet -9/25/24 11:41 PM one tablet -9/26/24 3:00 AM one tablet -9/27/24 10:10 PM one tablet, 7:00 PM one tablet -9/29/24 7:37 AM one tablet (next line under was illegible date with no time or signature documented one tablet) -9/30/24 4:50 PM one tablet Review of the 9/2024 MAR instructed staff to administer the following oxycodone medication: Oxycodone 10 mg one tablet three times a day for pain start date 9/18/24. No oxycodone 10 mg was documented on the NLB. Oxycodone five mg one tablet three times a day start date 9/25/24: no oxycodone five mg one tablet scheduled three times a day was documented on the NLB. Oxycodone five mg one tablet every 12 hours PRN start date 9/18/24: -9/19/24 at 12:36 AM date and time matched with oxycodone one tablet every four to six hours. -9/19/24 at 12:38 PM no match found on the NLB. Oxycodone five mg every four hours as needed one to two tablets start date 9/10/24 discontinued 9/17/24. No match found on the NLB. Oxycodone five mg every four hours PRN start date 9/17/24 and discontinued on 9/18/24. No match found on the NLB. On 10/16/24 at 11:28 AM Staff 1 (Administrator), Staff 2 (DNS) and Staff 37 (Regional Nurse Consultant) stated she reviewed Resident 20's medications and Resident 20 received medications as physician ordered, but staff used the same page in the NLB after changes in Resident 20's physician orders.