

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER South Hills Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1166 E. 28th Avenue Eugene, OR 97403	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders for 1 of 3 sampled residents (#208) reviewed for medications. This placed residents at risk for unmet treatment needs. Findings include: Resident 208 was admitted to the facility in 7/2025 with diagnoses including diabetes and diabetic kidney complications. The 9/2025 DAR instructed staff to administer insulin glargine twice a day for diabetes management. During the 8:00 AM administration, Staff 5 (LPN) documented Resident 208 was absent from the facility without her/his medications on five occasions. On 11/21/25 at 1:05 PM, Staff 5 (LPN) stated Resident 208 left the facility before her shift began and returned in the afternoon following dialysis. Staff 5 reported she did not know what the night nurse had completed or whether insulin was sent with the resident to the dialysis appointment. On 11/24/25 at 10:18 AM, Staff 28 (Regional Nurse) stated she would expect the physician to be involved in developing a clinical plan for insulin administration while the resident was out of the facility.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on interview and record review it was determined the facility failed to provide respiratory care and services for 1 of 3 sampled residents (#201) reviewed for respiratory services. This placed residents at risk for unmet respiratory needs. Findings include:Resident 201 was admitted to the facility in 12/2024 with diagnoses including chronic respiratory failure. A physician order dated 12/22/24 instructed staff to administer oxygen at three liters per minute continuously, every shift. A Physical Therapy Treatment Encounter Note dated 12/31/24 indicated Staff 20 (Former Physical Therapist Assistant) entered Resident 201's room and found the oxygen concentrator was not on. Resident 201's oxygen level was at 88 percent. After oxygen was administered, the level increased to 93 percent. A public complaint was received on 2/25/25, which alleged when Resident 201 was returned to her/his room, staff did not turn on her/his oxygen concentrator. Several hours later, Staff 20 came into the room and found the concentrator off. On 11/21/25 at 10:02 AM, Staff 20 confirmed the note was accurate and the oxygen concentrator was off when entering Resident 201's room on 12/31/24. On 11/24/25 at 10:17 AM, Staff 1 (Administrator) confirmed staff were expected to follow physician orders for Resident 201's oxygen use.</p>		