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Form Approved OMB
No. 0938-0391

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	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Hills Rehabilitation Center	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined the facility failed to follow physician's orders for 3 of 5 (#s 1, 3, and 5) sampled residents reviewed for critical lab values and medication errors. The facility failed to follow physician's orders on [DATE] to send Resident 1 to the Emergency Department after a critical lab value was received. The resident died on [DATE]. This put residents at risk for medication errors and death. Findings include: 1. Resident 1 admitted to the facility in 1/2026 with diagnoses including multiple fractures of the spine and kidney disease. A [DATE] admission MDS indicated Resident 1 was cognitively intact. Review of Resident 1's medical record indicated a critical lab value for low red blood cell count was called in to the facility on [DATE] at 12:35 PM. A hospital communication note written by Staff 3 (On Call Physician) on [DATE] at 1:48 PM indicated Staff 3 was aware of the critical lab value for Resident 1, Staff 3 completed a virtual assessment of Resident 1 and ordered Resident 1 to be sent to the Emergency Department (ED) for a possible blood transfusion. During an interview on [DATE] at 12:17 PM, Staff 5 (LPN) stated when she arrived for her shift (2-10 PM) on [DATE] the morning nurse, Staff 4 (Agency LPN), was speaking with Staff 3 about Resident 1 on an iPad. Staff 5 heard Staff 3 tell Staff 4 to send the resident to the ED, and to call her/his family. Staff 5 stated she heard Staff 3 ask to speak with the resident and Staff 4 took the iPad to the resident's room. Staff 5 stated when Staff 4 returned from the resident's room, she began gathering the necessary paperwork to send Resident 1 to the ED. Staff 5 stated Staff 4 did not inform her of the critical lab value or the need to complete Resident 1's transfer to the ED. Staff 5 stated during her shift she noticed Resident 1 was still in her/his room and assumed she/he had refused the transfer to the ED but did not ask Resident 1. Staff 5 stated Staff 7 (Certified Occupational Therapy Assistant) told her of Resident 1's low blood pressure the evening of [DATE] and she told Staff 7 to give the resident a drink of water. Staff 5 stated she gave Resident 1 medication for nausea twice throughout the evening of [DATE]. Staff 5 stated when she left her shift on [DATE] Resident 1 was communicative and responsive. During an interview on [DATE] at 12:55 PM, Staff 4 stated on [DATE] at 1:50 PM she received a call from the lab regarding a critical value for a low red blood cell count for Resident 1 and she called Staff 3 for further guidance. She stated Staff 3 spoke with Resident 1 via an iPad and completed a (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

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 02/09/2026
NAME OF PROVIDER OR SUPPLIER South Hills Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1166 E. 28th Avenue Eugene, OR 97403	

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F 0684 Level of Harm - Actual harm Residents Affected - Few	virtual assessment. Staff 4 stated Staff 3 told her to send Resident 1 to the ED via non-emergent transport, and Staff 3 would call the hospital to inform them Resident 1 would be coming into the ED. Staff 4 stated when she asked Staff 6 (LPN), what it meant to be non-emergent for a transport, she was told it meant the resident could be sent to the ED at any time. Staff 4 stated she wrote a nurses note and left the transfer for Staff 5 to complete on the next shift. No order for sending Resident 1 to the ED was found in Resident 1's medical chart. A nursing note was found to have been written on [DATE] at 1:28 PM (the next day) by Staff 4. The note indicated a critical lab value was called in to the facility on [DATE], she called Staff 3, Staff 3 assessed the resident, and ordered Staff 4 to send Resident 1 to the ED. During an interview on [DATE] at 2:17 PM, Staff 6 stated on [DATE] Staff 4 asked her about sending residents out via non-emergent transport. She stated she assisted Staff 4 by defining the term and finding the phone number of who to call for the transport. Staff 6 stated when she came in for her shift at about 5:45 AM on [DATE] the night shift nurse informed her Resident 1 had just died. Staff 6 stated she was not aware Resident 1 was who Staff 4 was asking about on [DATE]. A progress note dated [DATE] at 5:50 AM indicated Resident 1 died. During an interview on [DATE] at 4:37 PM, Staff 7 stated on [DATE] she informed Staff 5 of a low blood pressure reading for Resident 1 as well as changes in cognition, increased fatigue, nausea, and pale skin. She stated the nurse told her to have the resident drink water and retake the blood pressure. Staff 7 stated when Staff 5 heard the new blood pressure reading, Staff 5 stated she was no longer concerned. Staff 7 stated she did not see Staff 5 assess Resident 1 after hearing Resident 1's symptoms. During an interview on [DATE] at 1:43 PM, Staff 3 stated she was called by Staff 4 on [DATE] at 1:48 PM regarding a critical lab value for Resident 1. Staff 3 stated she completed a virtual assessment and spoke with Resident 1 who told her she/he wanted to go to the ED. Staff 3 stated she told the resident she would be sending her/him to the ED that day ([DATE]) for assessment and a possible blood transfusion. Staff 3 stated she told Staff 4 to have Resident 1 sent to the ED via non-emergent transport and called the ED to inform them about Resident 1's upcoming arrival and plan of care. Staff 3 stated her order was very clear to send Resident 1 to the ED, she expected Resident 1 to go to the ED for a transfusion, and she did not know Resident 1 was not sent to the ED as ordered. During an interview on [DATE] at 2:12 PM, Staff 2 (DNS) acknowledged at the time of the incident on [DATE], Staff 4 did not write a progress note regarding the critical lab value notification, did not put in Staff 3's verbal order to transport Resident 1 to the ED, did not act on the transport to ED order, and did not put in a progress note regarding Staff 3's verbal order to send Resident 1 to the ED. She stated her expectation for all nursing staff was for them to report all critical labs to the provider, receive guidance from the provider, inform the resident, act on the guidance from the provider, and then write a progress note. She stated her expectation for nurses was for them to put all verbal orders into the computer, follow the order as given by the provider, and then write a progress note. 2. Resident 3 was admitted to the facility in 1/2026 with diagnoses including sepsis (a (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	life-threatening reaction to infection). A [DATE] physician order indicated Resident 3 received Cefazolin (antibiotic) every eight hours. The 1/2026 MAR indicated Resident 3 received ceftriaxone (antibiotic) every eight hours. A [DATE] FRI indicated Resident 3 was admitted with orders for Cefazolin, but the orders were transcribed as ceftriaxone. Resident 3 was administered the wrong antibiotic 11 times. On [DATE] at 12:42 PM, Staff 2 (DNS) acknowledged the errors regarding Resident 3's medication administration. 3. Resident 5 was readmitted to the facility in 1/2026 with a diagnosis including PTSD (Post-Traumatic Stress Disorder). A [DATE] physician order indicated Resident 5 received quetiapine (antipsychotic) 100mg in the morning and at bedtime. A [DATE] FRI indicated during a care conference meeting for a GDR (Gradual Dose Reduction), it was noted Resident 5 was administered more quetiapine than ordered. Orders changed on [DATE] to receive 300 mg at bedtime and to discontinue the 100mg morning administration. The morning medication was not discontinued. On [DATE] at 12:42 PM, Staff 2 (DNS) acknowledged the errors regarding Resident 3's medication administration.