

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
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)		
F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to assess, develop, reassess and implement a person-centered care plan for dementia care needs to ensure resident safety for 4 of 4 sampled residents (#s 1, 2, 3, and 4) reviewed for elopement. As a result, Resident 1 left the facility on [DATE] without staff knowledge, had an incident involving her/his power wheelchair getting stuck outside on [DATE], and on [DATE] left the facility again, which placed the resident at risk for serious injury. Resident 1 lacked a comprehensive assessment and person-centered care plan for her/his dementia with Lewy bodies. There were no interventions developed and implemented to ensure the appropriate supervision and monitoring were in place to prevent an injury. Resident 1 was found deceased on [DATE] less than one mile from the facility and constituted substandard quality of care. A determination was made that the facility's noncompliance placed Resident 1 in immediate jeopardy, beginning [DATE]. On [DATE] at 12:10 PM, Staff 1 (Administrator) Staff 2 (DNS), Staff 4 (Regional Nurse Consultant), and Staff 48 (Regional Director of Clinical), were notified of the immediate jeopardy situation and provided a copy of the IJ template related to the facility's failure to assess Resident 1 who was a wander risk with diagnosis of dementia. Findings include: The facility's Elopements and Wandering Residents policy and procedures dated 7/2026, stated that residents who exhibit wandering behavior and/or are at risk for elopement receive appropriate interventions to attempt to mitigate accidents or elopements. The facility shall establish and utilize a systematic approach to be alert for and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Adequate supervision will be provided to help prevent accidents or elopements. The facility's Accident Hazard/Supervision/Devices policy and procedures undated, stated that the facility will provide an environment that is as free of accident hazards as is possible and provide supervision and assistance devices to avoid preventable accidents. Efforts to minimize risk to residents will include individualized, resident-centered interventions to reduce individual risks related to hazards in the environment. Interventions will be modified when necessary. Evaluation of hazards and accident risk data, which may include prior accidents/incidents and trends. Interventions will be based on the results of evaluation and analysis of information related to hazards and risks. 1. Resident 1 was admitted to the facility in 6/2026 with diagnoses including depression, hallucinations, and dementia with Lewy bodies (symptoms can include thinking speed, understanding, judgment, visual perception, hallucinations, changes between alertness and confusion which can happen unexpectedly). a. On (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 385167	Facility ID: 385167 If continuation sheet Page 1 of 14

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 11:58 AM, Staff 6 (CNA) stated Resident 1 left the facility on [DATE] due to a hallucination involving a party she/he wanted to attend and required staff assistance to return. b. On [DATE] at 8:22 AM, Staff 12 (CNA) stated on [DATE], Resident 1 was outside and got her/his power wheelchair stuck in the facility's garden area. Staff 12 stated the resident required assistance to get removed from the area. c. A Progress Note dated [DATE] at 11:11 PM, indicated Resident 1 was missing around 7:45 PM on [DATE] and staff last saw her/him at 4:30 PM. Police arrived around 10:00 PM to assist with the search for Resident 1. Resident 1's clinical record included admission documents from Resident 1's previous discharge location as follows: -An undated Summary Report indicated Resident 1 had severe physical limitations and recent cognitive decline. Resident 1 had a recent diagnosis of dementia with hallucinations and required 24-hour supervision to manage her/his hallucinations. Resident 1 was identified as a high fall risk due to cognitive impairment and total immobility. Resident 1 experienced frequent visual hallucinations three to four times a week, which required staff reassurance and redirection. Resident 1's cognitive status appeared stable, and she/he required a consistent environment to manage anxiety related to hallucinations. Resident 1 was considered independent in decision-making and could communicate her/his needs. -A [DATE] Assessment Summary indicated Resident 1 had hallucinations that began in 11/2025 and had been transferred to the emergency room a couple of times. Resident 1's hallucinations occurred approximately three to four times a week. Resident 1 reported difficulty navigating due to poor vision and poor depth perception, and Witness 2 (Family Member) stated Resident 1 could not navigate her/his wheelchair outside independently. Physicians had informed Resident 1 she/he should not use her/his wheelchair outside unassisted due to impaired cognition. Resident 1 stated she/he went outside once a month and needed staff assistance when she/he became stuck navigating corners or going through gates. The facility's [DATE] admission Evaluation indicated Resident 1 was care planned at risk for wandering with interventions to monitor location as necessary and attempt diversional activities. A [DATE] Occupational Therapy Evaluation and Plan of Treatment indicated Resident 1 had recent cognitive decline, impaired safety awareness, and limitations due to impaired attention. Resident 1's cognitive impairment was identified as a barrier likely to affect discharge planning. Resident 1's Care Plan dated [DATE] indicated she/he was at risk for elopement behaviors. On [DATE], Resident 1's elopement behaviors resolved. Resident 1's care plan did not include any person-centered care needs related to the resident's dementia with Lewy bodies or hallucinations in order to identify specific interventions to ensure the resident's safety. Resident 1's [DATE] Physician Orders indicated the resident was prescribed memantine (a medication to treat dementia) 5 mg at bedtime for dementia with hallucinations. Resident 1's admission MDS dated [DATE] indicated Resident 1 was severely cognitively impaired, with a BIMS of 5, and suffered from long-term hallucinations. Resident 1 had dementia and was able to communicate needs and had adequate vision. Resident 1 was dependent on all care and had a fall prior to admission. Resident 1's 6/2026 Cognitive Loss Dementia CAA stated the resident had a diagnosis of neurocognitive disorder with Lewy bodies, and the resident was able to communicate and make her/his needs known. Resident 1's CAA was not comprehensive and did not address the needs, functional status, strengths, weakness and goals related to the resident's dementia. Staff witness statements dated [DATE] indicated Resident 1 was last seen between 3:00 PM and 4:30 PM. Staff began searching for Resident 1 around 5:00 PM to 5:30 PM. A Resident Leaving the Facility investigation dated [DATE] indicated Resident 1 had dementia with Lewy bodies and longstanding history of hallucinations and psychosis. The facility's investigation noted Resident 1 currently had mild cognitive decline, with decreased hallucinations due to the use of memantine, and only one instance of exit seeking and wandering on [DATE]. Staff 7 (Resident 1's CNA) stated (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to develop assessments that were comprehensive and failed to complete assessments in a timely manner for 5 of 5 sampled residents (#s 1, 2, 3, 4, and 5) reviewed for MDS assessments. This placed residents at risk for unassessed and unmet care needs. Findings include: 1. Resident 1 was admitted to the facility in 6/2026 with diagnoses including depression, cataracts, contracture of foot, hallucinations, dementia with Lewy bodies (symptoms can include thinking speed, understanding, judgment, visual perception, hallucinations, changes between alertness and confusion without warning, slow movement, stiff limbs, unsteadiness, fainting and swallowing problems.) Resident 1's 6/12/26 CAAs indicate the following for each care areas: -Delirium CAA indicated the resident suffered from long-term hallucinations and monitors were in place for adverse reactions. -Visual Function CAA indicated the resident had cataracts in both eyes and could obtain an eye appointment if she/he chose. -Functional Abilities CAA indicated the resident was dependent on all ADLs, working with therapy, and required set-up for eating. -Urinary Incontinence indicated the resident was dependent on all care and could not move much. -Fall CAA indicated the resident had a fall prior to admit, was on high-risk medications which could increase risk for falls, and monitors were in place. -Psychotropic Drug Use CAA indicated the resident was taking medication for depression. Resident 1's CAAs were not comprehensive and did not include the resident's needs, strengths, goals, risk factors, or preferences. The resident's assessments did not document any findings and decisions to develop an individualized care plan. On 7/15/26 at 11:56 AM, Staff 43 (Former MDS Coordinator) stated she felt Resident 1's CAAs were comprehensive. 2. Resident 2 was admitted to the facility in 11/2025 with diagnoses including dementia with behavioral disturbance, and delusional disorders. Resident 2's 11/28/25 CAAs indicated the following for each care areas: -Functional Abilities CAA indicated the resident was at risk, needed assistance with most ADLs, and (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was working with therapy. -Psychotropic Drug Use CAA was blank with no documentation. Resident 2's CAAs were not comprehensive and did not include the resident's needs, strengths, goals, risk factors, or preferences. The resident's assessments did not document any findings and decisions to develop an individualized care plan. On 7/15/26 at 12:01 PM Staff 43 (Former MDS Coordinator) stated she felt Resident 2's CAAs were comprehensive enough for a CAA and covered a broad spectrum. 3. Resident 3 was admitted to the facility in 4/2026 with diagnoses including dementia. Resident 3's 4/10/26 CAAs indicated the following for each care areas: -Functional Abilities CAA indicated the resident required assistance with ADLs and was working with therapy to regain strength and balance. -Psychotropic Drug Use CAA indicated the resident took medication for depression. -Cognitive Loss/Dementia CAA indicated the resident was able to make needs known, asked for assistance when needed, and had a BIMS score of 12. Resident 3's CAAs were not comprehensive and did not include the resident's needs, strengths, goals, risk factors, or preferences. The resident's assessments did not document any findings and decisions to develop an individualized care plan. On 7/15/26 at 12:02 PM, Staff 43 (Former MDS Coordinator) stated she thought Resident 3's CAAs were comprehensive and the assessment covered the majority of stuff. On 7/15/26 at 1:53 PM, Staff 3 (Regional Director of Operations) confirmed residents' CAAs were not comprehensive. 4. Resident 4 was admitted to the facility in 7/2020 with diagnoses including schizophrenia. Resident 4's Annual MDS dated [DATE] had been completed on 7/14/26, which was overdue by 8 days. On 7/15/26 at 12:03 PM, Staff 43 (Former MDS Coordinator) verified Resident 4's Annual MDS had been completed late. 5. Resident 5 admitted to the facility in 4/2026 with diagnoses including heart failure. (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident's 5's Progress Note dated 5/29/267 indicated Resident 5 started hospice services. Resident 5's Significant Change in Status Assessment MDS was completed on 6/26/26, which was 14 days overdue. On 7/15/26 at 12:07 PM, Staff 43 (Former MDS Coordinator) verified the resident's 6/10/26 SCSA MDS was 14 days late.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and record review it was determined the facility failed to develop, implement, and maintain an effective training program related to behavior health care and services for 1 of 1 training program reviewed for staff training. This placed residents at risk for unmet behavioral health care needs. Findings include: Review of the facilities annual and new hire staff training revealed no behavioral health care training. On 7/15/26 at 12:30 PM Staff 4 (Regional RN) verified the facility did not have a behavioral training program in place. On 7/15/26 at 12:33 PM Staff 1 (Administrator) stated the facility cared for a large number of residents with behavioral concerns.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review it was determined the facility failed to notify the resident's representative for 1 of 4 sampled residents (#1) reviewed for elopement. This placed resident representatives at risk for lack of notification and participating in treatment decisions. Findings include: Resident 1 was admitted to the facility in 6/2026 with diagnoses including depression, cataracts, contracture of foot, hallucinations, dementia with Lewy bodies. a. On 7/9/26 at 11:58 AM, Staff 6 (CNA) stated on 7/3/26 at around 8:00 PM she noticed Resident 1 was missing. Resident 1 had gone about a block away and was in the street. On 7/9/26 at 12:47 PM, Staff 7 (LPN) stated on 7/3/26 at around 8:00 PM, she noticed Resident 1 as missing. Resident 1 was approximately a block away in her/his motorized wheelchair. Staff 7 did not feel it was a resident elopement and did not report the incident. On 7/9/26 at 7:49 AM, Witness 2 (Resident 1's Representative) stated he was never notified of Resident 1 eloping from the facility on 7/3/26. There was no documented evidence Witness 2 was notified of Resident 1's elopement from the facility on 7/3/26. On 7/15/26 at 1:56 PM, Staff 2 (DNS) stated she would expect Witness 2 to be contacted for the 7/3/26 elopement. b. On 7/13/26 at 8:22 AM, Staff 12 (CNA) stated she was informed by another facility resident that Resident 1 was outside and needed help. Staff 12 stated she observed Resident 1 by the street sidewalk and had her/his power wheelchair stuck in a flower bed. Staff 12 stated other staff assisted the resident, and she reported the incident to the nurse on duty. On 7/9/26 at 7:49 AM, Witness 2 (Resident 1's Representative) stated he was never notified of Resident 1's incident on 7/4/26. There was no documented evidence Witness 2 was notified of Resident 1's incident on 7/4/26. On 7/15/26 at 1:56 PM, Staff 2 (DNS) stated she would expect Witness 2 to be contacted for the 7/4/26 incident. c. A Progress Note dated 7/6/26 at 11:11 PM by Staff 2 (DNS) indicated Resident 1 was missing from the facility around 7:45 PM on 7/5/26. Staff reported last seeing the resident at 4:30 PM. Staff 1 (Administrator) was notified and police arrived around 10:00 PM to assist with the search. On 7/9/26 at 7:49 AM, Witness 2 (Resident 1's Representative) stated the facility notified him after Resident 1 had been missing for four hours. He indicated Resident 1 left the facility at approximately 4:00 PM and they did not contact him until approximately 8:00 PM. On 7/9/26 at 1:48 PM, Staff 15 (CNA) stated she noticed Resident 1 was missing on 7/5/26 at approximately 5:00 PM and it was a chaotic day. Staff 15 stated she reported Resident 1 was missing.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to submit a potential allegation of neglect in a timely manner to the State Agency for 1 of 3 sampled residents (#1) reviewed for elopement. This placed residents at risk for allegations of neglect not being investigated in a timely manner. Findings included: Resident 1 was admitted to the facility in 6/2026 with diagnoses including depression, cataracts, contracture of foot, hallucinations, swan neck deformity, dementia with Lewy bodies. The facility's Incident Report dated [DATE] indicated Resident 1 eloped from the facility on [DATE] and was found three days later on [DATE] deceased . A [DATE] FRI was received by the State Agency on [DATE]. Resident 1 left the facility on [DATE]. The FRI was submitted to the State Agency three days late. On [DATE] at 1:47 PM Staff 2 (DNS) stated she didn't report Resident 1's elopement because she did not believe it was an elopement. Staff 2 stated she would expect the facility to report incidents of elopements to the State Agency.		

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 07/15/2026
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review it was determined the facility failed to ensure an accurate assessment was completed for 1 of 5 sampled residents (#5) reviewed for MDS assessments. This placed residents at risk of unassessed needs. Findings include: Resident 5 admitted to the facility in 4/2026 with diagnoses including heart failure. Resident 5's 5/29/26 signed Hospice Care Plan indicated Resident 5 was at end of life. The 6/10/26 SCSA MDS Section J, indicated Resident 5 was not at her/his end of life. On 7/15/26 at 12:07 PM Staff 43 (Former MDS Coordinator) verified the 6/10/26 SCSA MDS assessment was inaccurate.		

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 07/15/2026
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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(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. Based on observation, interview and record review it was determined the facility failed to ensure the resident's environment remained free from accident hazards for 1 of 5 sampled residents (#2) reviewed for elopement. This placed residents at risk for elopements and accidents. Findings include: Resident 2 was admitted to the facility in 11/2025 with diagnoses including dementia. A 3/30/26 Quarterly MDS indicated Resident 2 was severely cognitively impaired. A Care Plan, revised 5/22/26, indicated Resident 2 was at risk for elopement (leaving without permission) and had a history of attempts to leave the facility unattended. Interventions included an elopement prevention device and verifying placement every shift. Resident 2's 6/28/26 Physician Orders, indicated the resident had a Wander Guard (a device used to monitor movement) on the left ankle, with instructions to monitor placement every shift, which started on 12/7/25. There was no documented evidence Resident 2's Wander Guard was regularly checked for its functionality. On 7/13/26 at 10:03 AM, Staff 17 (CNA) stated nurses had asked CNAs to verify if Resident 2's Wander Guard was in place. Staff 17 stated she had not checked for functionality of the residents wander guard. On 7/14/26 at 9:03 AM, Staff 23 (LPN Unit Manager) stated checking for functionality was not a protocol of the facility. The facility had not realized checking the functionality was a task they were supposed to complete. On 7/15/26 at 1:55 PM, Staff 4 (Regional Nurse Consultant) stated functionality checks for WanderGaurds might not appear in a resident's clinical record and may be completed by maintenance. Staff 4 stated she would check for the report. No additional information was provided.		

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 07/15/2026
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review it was determined the facility failed to designate a staff member responsible for the coordination of hospice care for 1 of 1 sampled resident (#5) reviewed for hospice. This placed residents at risk for uncoordinated hospice care. Findings include: Resident 5 admitted to the facility in 2/2026 with diagnoses including heart failure. Resident 5's 7/14/26 Care Plan indicated the resident was on hospice. There was no documented evidence found in Resident 5's clinical record that identified a designated staff member who was responsible for coordinating care between the facility and with hospice. On 7/15/26 at 11:28 AM, Staff 44 (LPN/Unit Manager) stated the main contact for hospice staff was the charge nurse on duty that shift and the IDT team as a whole oversaw the resident's general care. Staff 44 further stated she was not the care coordinator for any hospice resident, and the facility did not have a designated care coordinator between hospice and the facility for Resident 5.		