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	08/11/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review the facility failed to assess a resident for safe self-administration of medication for 1 of 1 sampled resident (#15) reviewed for choices. This placed resident at risk for adverse side-affects. Findings include: Resident 15 was admitted to the facility in 7/2025 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and muscle weakness.No documentation was found in the clinical record to indicate the resident was assessed to self-administer her/his medication. On 8/6/25 at 8:17 AM, Resident 15 was observed sitting in her/his room with one inhaler on the bedside table and a second inhaler on the nightstand. Resident 15 stated staff were aware of the inhalers in her/his room. Resident 15 explained she/she uses the inhaler when her/his COPD flares up and expressed concern that if they had to wait 10 minutes for staff during a flareup, they would be dead.On 8/6/25 at 8:18 AM, Staff 27 (CNA) confirmed Resident 15 had an inhaler at her/his bedside and reported this to the charge nurse. Staff 27 stated she was unaware if the resident was authorized to have the inhaler and would need to confirm with the nurse. Staff 27 later confirmed Resident 15 had two inhalers at her/his bedside. On 8/6/25 at 8:20 AM, Staff 26 (LPN) stated he was aware residents are required to be assessed prior to keeping medications at the bedside but did not know if Resident 15 had been assessed. Staff 26 checked both inhalers and confirmed one inhaler had two doses remaining and the other had 200 doses remaining. Staff 26 stated he would follow up with administration to determine if the resident had been assessed to self-administer medications. Staff 26 left both inhalers in Resident 15's room. On 8/6/25 at 8:59 AM, Staff 6 (Corporate DNS) acknowledged resident 15 had two inhalers in her/his room. Staff 6 confirmed Resident 15 did not have an order to self-administer her/his inhalers and had not been assessed to self-administer medications.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:F580- Based on interview and record review the facility failed to notify the physician of a resident's change of condition for 1 of 2 sampled residents (#40 and 72) reviewed for hospitalizations. Findings include: Based on interview and record review the facility failed to notify the physician of a resident's change of condition for 1 of 2 sampled residents (# 72) reviewed for hospitalizations. Findings include: 1. Resident 72 was admitted to the facility in 5/2025 with diagnoses including acute kidney disease.An admission MDS dated [DATE] revealed Resident 72 had a BIMS score of 14, which indicated the resident was cognitively intact.A review of the nursing notes dated 6/1/24 at 6:44 PM, revealed nursing staff documented Resident 72's blisters forming on her/his chest were draining. The resident also complained of feeling she/he was on fire and being stabbed with needles. Resident 72 was sent to the emergency department. A review of Resident 72's medical records revealed the physician was not notified of the change of condition the evening of 6/1/24.On 8/08/2025 at 10:58 AM, Staff 6 (Corporate DNS) confirmed the lack of documentation and stated the physician was not notified. On 8/08/2025 at 10:58 AM staff 2 (Director of nursing) and staff (Regional nurse) acknowledged physician notification had not occurred.

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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. (continued on next page)

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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	Based on observation, interview and record review it was determined the facility failed to ensure residents were free from abuse for 2 of 3 sampled residents (#s 43 and 49) reviewed for abuse. This placed residents at risk for further abuse. Findings include:The Abuse Policy revised 5/14/23 stated abuse included verbal abuse. The policy applies to any person who is an owner, operator, employee, manager, agent or contractor of the facility. It further states it is not necessary for the reporter to categorize the event as abuse for the facility to consider the potential for abuse and act accordingly.1. Resident 43 was admitted to the facility in 6/2025 with diagnoses including respiratory failure.Resident 43's admission MDS from 6/2025 revealed a BIMS score of 14, indicating the resident was cognitively intact.A progress note on 7/23/25 revealed a resident verbally abused a Spanish-speaking resident who was visiting with her/his family by making comments including, these people need to go back to where they belong, they are taking over. I thought these was the United States (sic). A progress note dated 7/30/25 revealed the resident again yelled at the Spanish-speaking resident, who was speaking on the telephone at the time. On 8/7/25 at 4:50 PM, Witness 1 (family) stated another resident at the facility had rude outbursts demanding, why don't you speak English this is America speak English (sic), and on 8 different occasions multiple family members, as well as staff and residents, witnessed these verbal outbursts. Witness 1 stated the staff apologized to Resident 43 and made her stay away instead of dealing with the resident who was having outbursts. Witness 1 stated Resident 43 was sitting in the dining area on a phone call, and the other resident was watching TV. She/he told Resident 43, shut up. Why can't you speak English? You are in America (sic), and continued being rude, obnoxious and disrespectful. Witness 1 stated the facility staff told the family to ignore the other resident. On 8/8/25 at 10:06 AM, Witness 2 (Community Partner) stated Resident 43's family called her and wanted to file a complaint about the facility's failure to intervene because another resident was making racial slurs toward the resident and her/his family. Witness 2 stated the family member told her the statements were making the resident uncomfortable, and even though Resident 43 was not sure what was being said, (Resident 43) knows it is bad. Witness 2 also stated the family member told her the resident no longer wanted to go into the communal areas of the facility because of the hostile behavior of the other resident. On 8/8/25 at 11:30 AM, Staff 26 (LPN) stated if there were verbal confrontations between residents, he was trained to speak with the residents then talk to the unit manager, and, if necessary, follow up with the DNS. He stated he was not sure why Resident 43 was moved to another room and stated he was not aware of verbal aggression toward Resident 43. Staff 26 stated most of the time Resident 43 would go outside when she/he was out of her/his room and had not been sitting in the dining room recently.On 8/11/25 at 8:00 AM, Staff 20 (Nursing Assistant) stated Resident 43 did not want to come into the second-floor dining area when the other resident was there because the other resident said racist things to Resident 43. Staff 20 stated Resident 43 would go outside instead of being in the second-floor common area to avoid the resident. Staff 20 stated she was not aware of facility staff doing anything to stop the verbal abuse by the resident. She stated Resident 43 talked to her about it because she speaks Spanish and took the time to listen to Resident 43's concerns. Staff 20 stated she recognized the other resident's behavior as verbal abuse.On 8/11/25 at 12:45 PM Resident 43 stated she/he was talking with her/his grandson and his girlfriend in the common area and another resident turned and stared at them and said, Why are you guys speaking in Spanish don't you know you are in America (sic)? Resident 43 stated the other resident kept talking but the staff ignored it. Resident 43 stated there were other times the same resident made racial comments to her/him and her/his family. When her/his grandson came back the next time, staff took him aside and told him not to take it personal and just ignore the resident's comments. Her/his grandson was very upset by the staff's comments.Resident 43 stated she/he was on phone with her/his granddaughter and the other resident started making racial comments again so Resident 43 ended her/his phone call. A CNA asked Resident 43 if she/he wanted to go to another room or table and the other resident just kept saying things. Resident 43 confirmed she/he would not go out in the common areas if the other resident was there, so she/he goes outside or stays away from the common area. Resident 43 stated she/he feels targeted because she/he is from a different race and stands out from the rest of the residents. Resident 43 stated she/he was moved to another hall to be further away from the other resident.On 8/11/25 at 3:30 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they learned of the verbal abuse to Resident 43 on 8/8/25. Staff 3 (Vice President of Operations) entered the room and much of the conversation was repeated. 2. Resident 49 was admitted to the facility in 3/2025 with diagnoses including

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	385167	A. Building B. Wing	08/11/2025

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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 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. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review it was determined the facility failed to prevent abuse for 2 of 3 residents (#s 43 and 49) reviewed for abuse. This placed residents at risk for abuse. Findings include: The Abuse Policy revised 5/14/23 states abuse included verbal abuse. The policy applies to any person who is an owner, operator, employee, manager, agent or contractor of the facility. It further states it is not necessary for the reporter to categorize the event as abuse for the facility to consider the potential for abuse and act accordingly and it remains the responsibility of the covered individual to verify the report (to appropriate entity) timely.1. Resident 43 was admitted to the facility in 6/2025 with diagnoses including respiratory failure.Resident 43's admission MDS completed in 6/2025 revealed a BIMS score of 14, indicating the resident was cognitively intact. A progress note on 7/23/25 revealed a resident verbally abused a Spanish-speaking resident who was visiting with her/his family by making comments including, these people need to go back to where they belong, they are taking over. I thought these was the United States (sic). A progress note dated 7/30/25 revealed the resident again yelled at the Spanish-speaking resident, who was speaking on the telephone at the time. On 8/7/25 at 4:50 PM, Witness 1 (family) stated another resident at the facility made rude outbursts demanding, why don't you speak English? This is America, speak English (sic). On 8 different occasions multiple family members, as well as staff and residents, witnessed these verbal outbursts. Witness 1 stated the staff apologized to Resident 43 and made her stay away instead of dealing with the resident who was having outbursts. Witness 1 stated Resident 43 was in the facility sitting in the dining area on a phone call and the other resident was watching TV and told Resident 43, Shut up. Why can't you speak English? You are in America (sic), and continued being rude, obnoxious and disrespectful. Witness 1 stated the facility staff told them to ignore the other resident. On 8/8/25 at 10:06 AM, Witness 2 (Community Partner) stated Resident 43's family called her and wanted to file a complaint about the facility's failure to intervene because another resident was making racial slurs toward the resident and her/his family. Witness 2 stated the family member told her the statements were making the resident uncomfortable, and even though Resident 43 was not sure what was being said, (Resident 43) knows it is bad. Witness 2 also stated the family member told her the resident no longer wanted to go into the communal areas of the facility because of the hostile behavior of the other resident. On 8/11/25 at 12:45 PM Resident 43 stated she/he was talking with her/his grandson and his girlfriend in the common area and another resident turned and stared at them and then said, Why are you guys speaking in Spanish? Don't you know you are in America (sic)? Resident 43 stated the staff ignored it. Resident 43 stated there were other times the same resident made racial comments to her/him and her/his family. When her/his grandson came back the next time, staff took him aside and told him not to take it personal and just ignore the resident's comments. Her/his grandson was very upset by the staff's comments.Resident 43 stated she/he was on phone with her/his granddaughter and the other resident started making racial comments again so Resident 43 ended her/his phone call. A CNA asked Resident 43 if she/he wanted to go to another room or table while the other resident just kept saying things. On 8/5/25 Staff 1 (Administrator) was asked to provide copies of all internal and facility-reported incidents (FRI) involving alleged abuse. Staff 1 did not provide any documentation of an investigation or FRI for the events related to verbal abuse of Resident 43. On 8/11/25 at 3:30 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they learned of the verbal abuse to Resident 43 on 8/8/25. During the interview with Staff 1 and Staff 2, Staff 3 (Vice President of Operations) entered the room and much of the conversation was repeated. 2. Resident 49 was admitted to the facility in 3/2025 with diagnoses including dementia and anxiety.Resident 49's St. Louis Mental Status Exam (SLUMS) was 2/30 indicating mild cognitive impairment. On 8/4/25 at 10:35 AM, Resident 49 stated her/his former roommate and Resident 49 had been arguing about the volume of the televisions in the room. Resident 49 stated a staff person came into the room and talked with them and when the staff person left the roommate made a racial slur. Resident 49 stated she/he was moved to her/his current room after the argument. Resident 49 stated as a result of the comment, she/he no longer wants to go out into the facility because she/he does not want to interact with the other resident.On 8/5/25 Staff 1 (Administrator) was asked to provide copies of all internal and facility-reported incidents (FRI) involving alleged abuse. Staff 1 did not provide any documentation of an investigation or FRI for the events related to verbal abuse of Resident 49. On 8/11/25 at 3:30 PM, Staff 1 and Staff 2 (DNS) stated Resident 49 suffered from a urinary tract infection at the time of the argument with her/his roommate which caused her/him to be confused. During the interview with Staff 1 and Staff 2, Staff 3

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	08/11/2025

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to report an allegation of abuse for 3 of 3 sampled residents reviewed for abuse resident (#s 43, 49 and 69). This placed residents at risk for uninvestigated abuse. Findings include: The Abuse Policy revised 5/14/23 states abuse included verbal abuse. The policy applies to any who is an owner, operator, employee, manager, agent or contractor of the facility. It further states it is not necessary for the reporter to categorize the event as abuse for the facility to consider the potential for abuse and act accordingly and it remains the responsibility of the covered individual to verify the report (to appropriate entity) timely.1. Resident 43 was admitted in 6/2025 with diagnoses including respiratory failure.Resident 43's admission MDS completed in 6/2025 revealed a BIMS score of 14, indicating the resident was cognitively intact.1. Resident 43 was admitted in 6/2025 with diagnoses including respiratory failure.Resident 43's admission MDS completed in 6/2025 revealed a BIMS score of 14, indicating the resident was cognitively intact.A progress note on 7/23/25 revealed a resident verbally abused a Spanish-speaking resident who was visiting with her/his family by making comments including, these people need to go back to where they belong they are taking over. I thought these was the United States (sic). A note dated 7/30/25 revealed the resident again yelled at the Spanish-speaking resident, who was speaking on the telephone at the time. On 8/7/25 at 4:50 PM, Witness 1 (family) stated another resident at the facility had rude outbursts demanding, why don't you speak English this is America speak English (sic), and on 8 different occasions multiple family members, as well as staff and residents, witnessed these verbal outbursts. Witness 1 stated the staff would apologize to Resident 43 and make her stay away instead of dealing with the resident who was having outbursts. Witness 1 stated Resident 43 was in the facility sitting in the dining area on a phone call and the other resident was watching TV and told telling Resident 43, Shut up why can't you speak English you are in America (sic), and continued being rude, obnoxious and disrespectful. Witness 1 stated the facility staff had not discussed the outbursts with the family other than to tell them to ignore the other resident. On 8/8/25 at 10:06 AM, Witness 2 (Community Partner) stated the Resident 43's family called her and wanted her to file a complaint about the facility's failure to intervene because another resident was making racial slurs toward the resident and her/his family. Witness 2 stated the family member told her the statements were making the resident uncomfortable, and even though Resident 43 was not sure what is being said, (Resident 43) knows it is bad. Witness 2 also stated the family member told her the resident no longer wanted to go into the communal areas of the facility because of the hostile behavior of the other resident. On 8/11/25 at 12:45 PM Resident 43 stated she/he was talking with her/his grandson and his girlfriend in the common area and another resident turned and stared at them and then said, Why are you guys speaking in Spanish don't you know you are in America (sic)? Resident 43 stated the other resident kept talking and saying other things but the staff ignored it. Resident 43 stated there were other times the same resident made racial comments to her/him and her/his family. When her/his grandson came back the next time staff took him aside and told him not to take it personal and just ignore the resident's comments and her/his grandson was very upset by the staff's comments.Resident 43 stated she/he was on phone with her/his granddaughter and the other resident started making racial comments again so Resident 43 ended her/his phone call. A CNA asked Resident 43 if she/he wanted to go to another room or table and the other resident just kept saying things. On 8/5/25 Staff 1 (Administrator) was asked to provide copies of all internal and facility-reported incidents (FRI) involving alleged abuse. Staff 1 did not provide any documentation of an investigation or FRI for the events related to verbal abuse of Resident 43. On 8/11/25 at 3:30 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they learned of the verbal abuse to Resident 43 on 8/8/25, implying they had not had time to initiate an investigation. During the interview with Staff 1 and Staff 2, Staff 3 (Vice President of Operations) entered the room and much of the conversation was repeated. Staff 3 stated, Thank you, we will look into this.2. Resident 49 was admitted to the facility in 3/2025 with diagnoses including dementia and anxiety.A Psychiatric Evaluation conducted 5/13/25 indicated Resident 43 had a SLUMS On 8/4/25 at 10:35 AM, Resident 49 stated her/his former roommate and Resident 49 had been arguing about the volume of televisions in the room. Resident 49 stated a staff person came into the room and talked with them and when the staff person left the roommate made a racial slur. Resident 49 stated the slur was not made directly at her/him but was stated at a volume Resident 49 would not be able to avoid hearing. Resident 49 was very reserved in his language and bearing and would not repeat the exact language her/his former resident used. Resident 49 stated she/he was moved to her/his

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	385167	A. Building B. Wing	08/11/2025

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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 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 interview and record review the facility failed to inform the resident of the Bed Hold Policy for 2 of 2 sampled residents (#40 and 72) reviewed for hospitalization. This placed residents at risk for being uninformed of their rights. Findings include: Resident 40 was admitted to the facility in 1/2023 with diagnoses including Type 2 diabetes mellitus. Resident 40 has a BIMS of 15 (cognitively intact). The undated Bed Hold Policy stated before the facility transferred a resident to a hospital the facility shall provide the resident a copy of the Bed Hold Policy and document in the resident's record whether the resident or resident's representative declined or agreed to pay to hold the bed. According to the policy, if a resident was unable to make a decision due to physical or mental incapacity and there was no legal representative to make a decision, the information would be documented in the resident's clinical record. A 3/4/25 Progress Note indicated Resident 40's roommate informed staff Resident 40 had fallen. Resident 40 was falling asleep as staff attempted to assess her/his condition and her CBG (blood glucose) was 63. The resident began exhibiting agonal breathing (an abnormal, gasping pattern of respiration that often indicates a medical emergency) and EMS was called. Resident 40 was transported to the hospital by EMS. On 8/7/24 at 4:28 PM, Staff 23 (LPN) stated the process when a resident needs to be sent to the hospital was to notify the doctor and unit manager and if it was a crisis, to call 911 and request an ambulance. Staff 23 stated if the resident was coherent, they would offer them a bed hold verbally but not provide a written notice. On 8/7/25 at 4:35 PM, Staff 8 (LPN/Unit Manager) stated staff were to call the family and inform them of the bed hold. On 8/7/25 at 4:53 PM, Resident 40 stated she/he was unconscious and not in any condition to get information when she/he was sent out the hospital on 3/4/25. Resident 40 stated she/he did not receive any paperwork from the facility when she/he was taken to the hospital. On 8/7/25 at 4:55 PM, Staff 3 (VP of Operations) stated the Discharge Transfer Notice was to be handed to the resident by nursing staff as they were wheeled out of the facility. On 8/7/25 at 5:05 PM, Staff 1 (Administrator) stated residents were supposed to get the pre-printed brochure and a copy of the Bed Hold Policy when they discharged to the hospital. 2. Resident 72 was admitted to the facility in 5/2025 with diagnoses including acute kidney disease. (continued on next page)

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	385167	A. Building B. Wing	08/11/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission MDS dated [DATE] revealed Resident 72 had a BIMS score of 14, which indicated the resident was cognitively intact. A review of the nursing notes dated 6/1/24 at 6:44 PM revealed the nurse documented Resident #72 developed blisters forming on her chest that are draining. The resident also complained of feeling she is on fire and being stabbed with needles. Resident was sent to emergency department. No documentation was found in clinical record informing resident 72 of Bed Hold Policy or written notice of transfer to the hospital. On 8/07/2025 5:32 PM Staff 2 (DNS) stated she could not find notice in clinical record for resident 72. On 8/07/2025 at 5:27 PM Staff 1 (Administrator) and Staff 2 (DNS) confirmed there was no bed hold notice given for resident 72. On 8/07/2025 5:39 PM, Staff 3 (VP of Operations) Staff 16 (SSD) did not give discharge and treatment notice, we dropped the ball.

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	385167	A. Building B. Wing	08/11/2025

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F 0684 Level of Harm - Minimal harm or potential for 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 interview and record review it was determined the facility failed to follow physician orders related to labs for 1 of 1 sampled residents (#62) reviewed for mood and behavior. This placed residents as risk for unmet needs. Findings include:Resident 62 was admitted to the facility on [DATE] with diagnoses including a stroke with fluency disorder (disrupts the natural flow of speech) and depression. The 7/28/25 psychiatric admission progress note indicated a new order for CBC (Complete Blood Count) lab.A review of Resident 62's medical record revealed no indication a CBC lab draw was obtained.On 8/11/25 at 2:22 PM Staff 2 (DNS) stated she was not aware of the laboratory order for Resident 62, and it was not completed.

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	385167	A. Building B. Wing	08/11/2025

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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 observations, interviews, and record reviews it was determined the facility failed to monitor a resident after a fall for 1 of 3 sampled residents (# 10) reviewed for accidents. This placed residents at risk for injury. Findings include: Resident 10 was admitted to the facility in 7/2025 with diagnoses including stroke. A Fall Investigation Report indicated that on 6/12/25 at 4:10 AM, Staff 24 (Former LPN) responded to Resident 10's call light and found her/him on the floor next to her/his bed. It was determined Resident 10 fell out of bed and her/his roommate activated the call light. Resident 10 was unable to recall how she/he ended up on the floor and did not know if she/he struck her/his head.On 6/12/25 at 4:10 AM, neurological checks were initiated. The Neurological Check Assessment form directed staff to complete neurological checks every 15 minutes for one hour, every 30 minutes for one hour, and every hour for four hours. Resident 10's clinical record contained documentation of only one neurological assessment.On 8/11/25 at 11:00 AM, Staff 23 (LPN) stated that when a resident experienced an unwitnessed fall, staff were expected to complete and document neurological assessments.On 8/11/25 at 11:32 AM, Staff 2 (DNS) stated nurses were expected to complete and document neurological checks following an unwitnessed fall. Staff 2 acknowledged neurological assessments were not completed for Resident 10.

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	08/11/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation and record review it was determined the facility failed to ensure adequate staffing for 15 out of 33 days for 1 of 1 facility reviewed for sufficient staffing. This placed residents at risk for unmet needs. Findings include:The Direct Care Staffing Daily Report forms 7/1/25 through 8/3/25 revealed the facility did not have sufficient CNA staffing for six out of 33 days reviewed. -7/3/25, (day shift).-7/4/25, (evening shift).-7/22/25, 7/5/25, 7/8/25, 7/19/25, (night shift). On 5/9/25 at 9:09 AM, Staff 25 (Regional Staffing Coordinator) confirmed the facility did not have sufficient staffing on the above dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to ensure staff properly washed hands for 2 of 3 kitchen staff observed. This placed residents at risk for foodborne illness. Findings include:On 8/4/25 at 12:12 PM, Staff 30 (Dietary Aide) grabbed a plate cover from other staff that had left kitchen and placed it on the dirty dish counter and went back to plating lunches without washing his hands. On 8/4/25 at 12:20 PM, Staff 30 washed his hands, shut off the water with a paper towel and then dried his hands with the same paper towel. On 8/4/2025 12:23 PM, Staff 31 (Prep Cook/Dietary Aide) opened the refrigerator to remove items. After completing her task she washed hands, turned off the faucet with wet hands then dried her hands with a towel. On 8/4/25 a 12:25 PM, Staff 30 washed his hands, turned off the faucet with wet hands and dried his hands with a paper towel before returning to plating food. On 8/4/2025 at 12:36 PM Staff 30 stated he was trained to turn off the faucet with a paper towel then dry his hands with it and had not been aware the towel he used to turn off the faucet was contaminated. On 8/4/25 at 12:41 PM, Staff 19 (Corporate Dietary Manager) was present in the kitchen during lunch preparation and stated Staff 30 and Staff 31 did not follow the correct hand washing procedure.

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	385167	A. Building B. Wing	08/11/2025

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview the facility failed to ensure refuse containers were covered for 1 of 1 exterior refuse containers. This placed residents at risk for pest infestations. Findings include:On 8/4/25 at 9:45 AM, the outdoor refuse container for the facility was observed during a walk through with Staff 9 (Dietary Manager) of the outdoor trash and recycling area for the facility. The lid to the dumpster was open with a gap of about twelve to fifteen inches between the lid and body of the dumpster at the front of the unit. Staff 9 stated the staff did not always close the dumpster because it was difficult to close. When Staff 9 attempted to close the lid of the dumpster, he was unable to do so and stated the cranking mechanism used to close the dumpster appeared to be broken.

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	385167	A. Building B. Wing	08/11/2025

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. (continued on next page)

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	08/11/2025

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to implement infection control practices to prevent the spread of clostridioides difficile (c-diff, a bacterium that can cause severe diarrhea and inflammation of the colon) for all residents, staff, and visitors for 1 of 1 sampled resident (#78). This failure, determined to be an Immediate Jeopardy situation, placed all residents, staff, and visitors at risk for exposure to c-diff, which is highly contagious and can cause serious illness, including life-threatening colitis and death. Findings include:The online reference CDC Preventing C-Diff. revealed the best way to prevent the spread of C-Diff from person to person was for all healthcare workers to wash their hands with soap and water before and after touching contaminated surfaces and for proper disinfection of bleaching surfaces. The online reference CDC How C-Diff. spreads revealed any surface, device or material that becomes contaminated with feces could serve as a reservoir for C- Diff spores. C- Diff spores can transfer to patients by the hands of healthcare personnel who have touched a contaminated surface or item. C-Diff can live on inanimate surfaces for up to five months. A contaminated wheelchair becomes a vector for transmission to other residents, staff, and visitors. The online reference CDC The Progression of C-Diff. Infection revealed C-Diff can be colonized, but the bacteria itself can be spread through spores even in the absence of detectable toxin levels. Resident 78 admitted to the facility on [DATE] with diagnoses including C-Diff, weakness, and nicotine dependence. A review of the 7/29/25 Hospital Discharge Summary revealed Resident 78 had a diagnosis of C-Diff. The C-Diff DNA revealed it was positive, and the toxin was negative (can indicate colonization rather than active infection). The resident was to continue with oral antibiotics through 8/5/25 and was to be on isolation enteric precautions (including PPE gloves and a gown, disinfect all equipment used before it left the room and hand washing with soap and water prior to exit of the room). A review of the 7/30/25 Smoking Safety Assessment revealed the resident was assessed for smoking safety and was deemed independent, able to smoke in the designated smoking area at the facility. A review of the facility floor plan revealed the designated smoking area for the residents was located on the second floor of the facility. The 7/30/25 care plan for C-Diff indicated Resident 78 was on contact isolation precautions and all equipment used was to be disinfected before it left the room. A review of the August 2025 MAR revealed Resident 78 completed a course of antibiotics on 8/3/25.Bowel records from 8/2/25 through 8/7/25 indicated Resident 78 had 13 bowel movements; nine were loose/diarrhea; bowel movements each day. The last loose stool was on 8/7/25 at 1:00 PM.On 8/4/25 at 1:53 PM Resident 78 was observed to exit her/his room independently on the first floor and self-propel the wheelchair down the hallway to the elevator. The resident did not disinfect her/his wheelchair before it left the room, and no staff members were observed to exit the resident's room after the resident.On 8/7/25 at 1:50 PM Resident 78 was observed to exit her/his room independently on the first floor and self-propelled the wheelchair down the hallway to the elevator. The resident did not disinfect her/his wheelchair before it left the room, and no staff members were observed to exit the resident's room after the resident.On 8/7/25 at 4:13 PM Resident 78 was observed to exit the elevator independently on the second floor and self-propel towards the back exit that led to the dedicated smoking area for residents. Staff 4 (CNA) greeted Resident 78 and asked if she/he wanted assistance outside; Resident 78 accepted. Staff 4 was observed to wheel Resident 78 to the back door, open the locked back door using a key card that was on her person with non-gloved hands and assist the resident by pushing the wheelchair outside to the smoking area. Staff 4 was observed to have re-entered the facility using her key card with a non-gloved hand and proceeded to her job duties without washing her hands with soap and water after assisting Resident 78. On 8/7/25 at 4:16 PM and at 6:21 PM Staff 4 stated she was unaware Resident 78 was on contact precautions. Staff 4 stated it was not communicated to staff who worked on the second floor any resident who was on transmission-based precautions from the first floor. Staff 4 confirmed she did not wash her hands with soap and water after contact with Resident 78's wheelchair. On 8/7/25 at 4:41 PM Staff 10 (CNA) and at 4:46 PM Staff 11 (CNA) both stated they worked on the second floor and were unaware of any resident who was on contact precautions from the first floor as that was not communicated to them. On 8/7/25 at 5:09 PM Staff 12 (CNA) stated he worked on the first and second floors and was aware of Resident 78's contact precautions; however, he was unsure how that was communicated to the staff on the second floor. On 8/7/25 at 5:15 PM Staff 13 (CNA) stated she worked on the second floor only and it was not communicated to her if any residents from the first floor were on contact precautions. On