

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Hillsboro Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1778 NE Cornell Road Hillsboro, OR 97124	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse to the State Agency for 2 of 2 sampled residents (#s 6 and 10) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 6 admitted 1/2025 with diagnoses including dementia. Resident 6's 6/9/25 MDS revealed Resident 6 had a BIMS of 5, which indicated a severe cognitive impairment. A 6/9/25 Sexual Capacity Evaluation indicated Resident 6 did not have sufficient memory and/or cognitive function to make the choice for sexual activity. Resident 10's 1/29/25 MDS revealed Resident 10 had a BIMS of 8, which indicated a moderate cognitive impairment. A 6/9/25 Sexual Capacity Evaluation indicated Resident 10 did not have sufficient memory and/or cognitive function to make the choice for sexual activity. On 8/11/25 at 1:04 PM, Staff 20 (CMA) stated she saw Resident 6 sitting on Resident 10's bed on 6/9/25. She stated Resident 10 was touching Resident 6's breasts and was offering Resident 6 money. She stated staff separated Resident 6 and Resident 10. On 8/11/25 at 1:07 PM, Resident 10 stated she/he did not remember the incident. Resident 6 was not able to be interviewed as she/he was no longer in the facility. On 8/12/25 at 10:17 AM, Staff 21 (RN) stated she saw Resident 6 go into Resident 10's room and she observed them kissing on 6/9/25. She stated staff re-directed Resident 6 away from Resident 10. On 8/12/24 at 11:58 AM, Staff 3 (LPN Resident Care Manager) stated Resident 6 and Resident 10 were observed kissing on 6/8/25 and 6/9/25. He was made aware on 6/9/25 and completed the sexual consent evaluations for each resident and determined neither Resident 6 nor Resident 10 could consent to intimate activity. On 8/12/25 @ 12:30 PM, Staff 1 (Administrator) stated he was unable to locate any evidence the event was reported to the State Agency and that it was his responsibility to report to the State Agency.</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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to investigate allegations of abuse for 2 of 2 sampled residents (#s 6 and 10) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 6 admitted 1/2025 with diagnoses including dementia. Resident 6's 6/9/25 MDS revealed Resident 6 had a BIMS of 5, which indicated a severe cognitive impairment. A 6/9/25 Sexual Capacity Evaluation indicated Resident 6 did not have sufficient memory and/or cognitive function to make the choice for sexual activity. Resident 10's 1/29/25 MDS revealed Resident 10 had a BIMS of 8, which indicated a moderate cognitive impairment. A 6/9/25 Sexual Capacity Evaluation indicated Resident 10 did not have sufficient memory and/or cognitive function to make the choice for sexual activity. On 8/11/25 at 1:04 PM, Staff 20 (CMA) stated she saw Resident 6 sitting on Resident 10's bed on 6/9/25. She stated Resident 10 was touching Resident 6's breasts and was offering Resident 6 money. She stated staff separated Resident 6 and Resident 10. On 8/11/25 at 1:07 PM, Resident 10 stated she/he did not remember the incident. Resident 6 was not able to be interviewed as she/he was no longer in the facility. On 8/12/25 at 10:17 AM, Staff 21 (RN) stated she saw Resident 6 go into Resident 10's room, and she observed them kissing on 6/9/25. She stated staff re-directed Resident 6 away from Resident 10. On 8/12/24 at 11:58 AM, Staff 3 (LPN Resident Care Manager) stated Resident 6 and Resident 10 were observed kissing on 6/8/25 and 6/9/25. He was made aware on 6/9/25 and completed the sexual consent evaluations for each resident and determined neither Resident 6 nor Resident 10 could consent to intimate activity. On 8/12/25 at 12:30 PM, Staff 1 (Administrator) stated he was unable to locate any evidence that the incident was investigated, and it was the Administrator's responsibility to complete the investigation.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 sampled resident (#5) reviewed for accidents. This placed residents at risk for injury due to accidents. Findings include: Resident 5 admitted in 7/2025 with diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left non-dominant side. Resident 5's 7/18/25 care plan indicated Device: Seat belt-gait belt from home and Mobility Device: Electric wheelchair, assist resident with seat belt. A 7/20/25 progress note indicated Resident 5 was found on the floor, stated she/he slid out of her wheelchair and called emergency from her/his personal cell phone. Resident 5 had a laceration on her/his leg and was bleeding. Resident 5 was taken to the hospital for evaluation. On 8/8/25 at 12:28 PM, Staff 12 stated Resident 5 slipped out of her/his wheelchair and onto the floor. He further stated he could not get Resident 5's seat belt around her/him because it was too small. He was unsure if use of the seat belt was in the care plan and stated he did not inform anyone the seat belt was too small because it was known. On 8/8/25 at 3:17 PM, Resident 5 reported she/he fell on the floor and her/his leg was bleeding. She/he yelled for help, but no one came. Resident 5 indicated she/he was scared and called 911 and was taken to the hospital. On 8/12/25 at 10:31 AM, Staff 22 (LPN) stated she saw Resident 5 during the morning medication pass. She did not know if Resident 5 was wearing a seat belt when she/he fell and was not sure if she/he was care-planned for its use. On 8/12/25 at 1:19 PM, Staff 1 (Administrator) stated he expected all staff to follow the care plan to prevent accidents.</p>		