STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385167	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTH HILLS REHABILITATION CEN	**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** - 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** 1. Based on interview and record review it was determined the facility failed to follow physician orders [REDACTED].#3) reviewed for dietary preferences. This placed residents at risk for unmet needs. Findings include: Resident 3 admitted to the facility in 1/2020 with [DIAGNOSES REDACTED]. A review of the 1/2020 MARS revealed Resident 3 did not receive her/his [MED], 40 units of [MED] two times daily until 1/24/20, three days later. On 2/25/20 at 3:06 PM Staff 3 (Unit Manager-LPN) stated the pharmacy had changed the initial order from [MEDICATION NAME] (a name brand [MED]) to [MED] (a generic [MED] brand) and facility staff should have initiated and administered the [MED] on 1/21/20 when the order was received. On 2/26/20 at 2:31 PM Staff 2 (DNS) confirmed orders from the pharmacy should have been accepted by staff on 1/21/20 when the pharmacy changed the [MEDICATION NAME] to the generic brand [MED] and Resident 3's [MED] should have been administered. 2. Based on interview and record review it was determined the facility failed to provide weekly skin assessments for 1 of 3 sampled residents (#4) reviewed for pressure ulcers. This placed residents at risk for skin breakdown. Findings include: Resident 4 was admitted to the facility in 1/2020 with [DIAGNOSES REDACTED]. A 1/7/20 a NSG Admission/Readmission Evaluation revealed no skins issues were identified. A 1/19/20 Skin/Wound and Total Body Skin Assessment was completed (12 days later) and revealed no new skin issues were identified. A review of the clinical record revealed no skin issues were identified and Resident 4 discharged the facility on 1/20/20. On 2/21/20 at 9:49 AM Witness 4 (Complainant) stated Resident 4 had a urology appointment on 1/14/20 at roughly 1:30 PM and she noted an approximate 12 cm dusky (a red area) appearance on the residents buttocks/pressure point region. Witness 4 stated there were no open areas on the buttocks and the resident did not express any pain. On 2/25/20 at 12:39 PM Staff 19 (CNA) stated Resident 4 was a one person transfer with toileting, able to utilize her/his call light and became agitated when attempting to assist her/him to the toilet and with ADL care needs. Resident 4 refused showers and repositioning in bed. Staff 19 stated the resident never reported pain on her/his buttock region and did not recall her/him having and pressure sores. On 2/25/20 at 2:02 PM Staff 17 (CNA) stated Resident 4 did not like to receive assistance with ADL care and would refuse ADL care including showers. Staff 17 stated he recalled the resident reported having a sore buttocks, however refused to let him see the area. Staff 17 stated he reported the concern to the nurse. On 2/25/20 at 3:54 PM Staff 12 (RN) stated she did not recall Resident 4, however stated skin checks were to be completed one time a week on all residents. Staff 12 stated she was not sure where to look to see if a resident needed a weekly skin check completed. Staff 12 was not sure how the list was generated for weekly skin checks and another staff would let her know who needed them. On 2/26/20 at 10:16 AM Staff 20 (LPN) and at 12:20 PM Staff 5 (LPN) both stated they did not recall any skin issues with Resident 4. Staff stated skin checks were to be completed weekly by LPNs and RNs and a full head to toe was to be completed on all residents. Staff 5 and Staff 20 stated a list was generated in the electronic system to know who needed skin evaluation completed. On 3/4/20 at 11:11 AM Staff 2 (DNS) acknowledged the delay in weekly skin checks for Resident 4. Staff 2 stated she expected weekly skin check to be completed for all resident. Staff 2 stated all nursing staff should know where to locate the skin audits and which residents needed skin audits completed weekly.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on interview and record review it was determined the facility failed to ensure narcotic drug records were in order and an account of all controlled drugs was maintained for 5 of 5 medication carts reviewed for medication administration. This placed residents at risk for drug diversion. Findings include: Inventory Control of Controlled Substances Revision Date 1/1/13: -Facility staff should ensure that the incoming and outgoing nurses count all scheduled controlled substances and other medication with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on the Controlled Substance Count Verification/Shift Count Sheet. On 2/21/20 at 11:50 AM the number six medication cart revealed 68 times out of 153 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 2/21/20 at 11:50 AM the number four medication cart revealed 31 times out of 87 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 2/21/20 at 11:50 AM the number five medication cart revealed 13 times out of 34 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 2/21/20 at 11:50 AM the number one medication cart revealed 30 times out of 99 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 2/21/20 at 11:50 AM the number two medication cart revealed 46 times out of 74 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 2/27/20 at 12:55 PM Staff (DNS) verified the missing signatures in the narcotic books. She stated the narcotics should be reconciled each shift and signatures should be completed by two nurses.

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

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.