

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Pilot Butte Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1876 NE Highway 20 Bend, OR 97701	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179</p> <p>Based on interview and record review it was determined the facility failed to ensure a resident was safe from elopement for 1 of 1 sampled resident (#1) reviewed for elopement. This failure was determined to be an immediate jeopardy situation due to the facility failed to follow the Resident 1's care plan and provide adequate supervision, which resulted in Resident 1's elopement from the facility. Findings include:</p> <p>Resident 1 admitted to the facility on ,d+[DATE] for a 5-day respite stay with diagnoses including Alzheimer's Disease, dementia, anxiety disorder and restlessness.</p> <p>On 9/5/24 at 11:53 AM, Witness 1 (Family) stated on 8/15/24 she was notified Resident 1 was found in the middle of a roundabout, confused and carrying a teddy bear by a local law enforcement officer. The officer notified Resident 1's family. Witness 1 stated Resident 1 told her she/he wanted to leave the facility so when someone opened the door, she/he walked out.</p> <p>The 8/12/24 BIMS (an assessment tool used to assess cognition) revealed Resident 1 had severe cognitive impairment.</p> <p>The 8/12/24 Ambulation Care Plan revealed Resident 1 was independent with ambulation.</p> <p>The 8/13/24 Behavior Care Plan revealed Resident 1 was at risk for behavior symptoms related to elopement due to dementia, sun downs (the emergence or worsening of symptoms, like agitation, confusion or aggressiveness, in the late afternoon or early evening) and her/his first time away from home. Interventions included to encourage Resident 1 to remain in a supervised area when out of bed, monitor every 15 minutes and to redirect when wandering.</p> <p>The 8/13/24 Elopement Evaluation revealed Resident 1 was at risk for elopement.</p> <p>The 8/13/24 Progress Note revealed Resident 1 was confused, wandered throughout the facility and was exit seeking.</p> <p>The 8/14/24 Progress Note revealed Resident 1 wandered around the facility trying to get out and stated she/he wanted to go home. Resident 1 attempted to open each door she/he approached, all she/he thought of was to leave and was a high elopement risk.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Pilot Butte Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1876 NE Highway 20 Bend, OR 97701	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The 8/28/24 Facility Investigation revealed Resident 1 was at the facility for a five day respite stay, was ambulatory, could almost run if [she/he] want to, went to every door in the facility to try and get out, set off two alarms, needed frequent visual checks and was a high risk for elopement and falls. On 8/15/24, Staff 6 (CNA) last observed Resident 1 between 5:30 PM and 5:45 PM when the resident walked back and forth in the hallway, appeared agitated and excited and stated, I want to go home. I am going home today. The investigation further indicated Witness 2 (Visitor) observed Resident 1 in the lobby when Resident 1 sat down and began to talk out loud to herself/himself. Resident 1 abruptly stood up and stated she/he was going for a walk and followed another visitor out the door. The investigation summary indicated Staff 5 (CNA) last saw the resident at 6:30 PM in her/his room and Witness 2 observed her/him in the lobby between 7:00 PM and 7:15 PM. Resident 1 was found in the street by a police officer at approximately 7:30 PM and the facility staff was notified of the elopement at 7:45 PM when Resident 1 was returned to the facility by the police officer.</p> <p>Per record review the distance from the facility to where the resident was found was approximately 1.8 miles. Per Google Earth and Mapquest, the resident would have walked alongside a four lane highway, crossed the highway, walked along a busy street and transversed through three roundabouts before she/he was found in the third roundabout by the local police.</p> <p>Record review revealed 30-minute visual checks were in place from 8/13/24 at 6:45 AM through 8/15/24 at 3:30 PM. Resident 1's visual checks stopped nearly four hours before she/he eloped on 8/15/24 after 7:00 PM. In addition, Resident 1's care plan of 15-minute checks was not followed.</p> <p>On 9/5/24 at 10:56 AM, Staff 5 stated she was the last person to observe Resident 1 at 6:30 PM, when she attempted to wake up the resident for dinner. This was 30-45 minutes before Resident 1's elopement. Staff 5 further stated, after a while, the police came saying she was missing.</p> <p>On 9/5/24 at 11:20 AM, Staff 8 (CNA) stated Resident 1 was very confused, stayed by the door and was exit seeking the entire time at the facility. If staff attempted to redirect her/him, Resident 1 would get very angry, shake, grind her/his teeth and then immediately begin to exit seek again out all of the doors.</p> <p>On 9/6/24 at 11:46 AM, Staff 9 (CNA) stated Resident 1 was exit-seeking and pulling on the doors, but did not see any staff redirect her/him and did not redirect Resident 1 herself.</p> <p>On 9/5/24 at 12:37 PM, Staff 12 (CNA) stated Resident 1 was exit-seeking from the moment she/he woke up and constantly tried to find a way out using any of the four doors. Staff 12 further stated all staff were aware of the exit seeking behavior but did not redirect Resident 1 unless she/he was at the main entry door. Staff 12 stated not all staff on evening and night shift were aware of the care planned safety checks so the checks did not always get done.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Pilot Butte Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1876 NE Highway 20 Bend, OR 97701	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 9/5/24 at 12:20 PM, Staff 2 (DNS) and Staff 4 (Admission Nurse/Resident Care Manager) verified Resident 1 was a high risk for elopement. Staff 2 stated Resident 1's care plan should have had individualized interventions in place to prevent elopement and acknowledged there was no documented evidence Resident 1's care plan was followed by encouraging her/him to remain in a supervised area when out of bed, monitoring her/his location every 15 minutes and redirecting when she/he wandered. Staff 2 stated the every 30 minute monitoring fell off at 3:30 PM on 8/15/24 because staff were unaware of the need to do this. Staff 2 acknowledged Resident 1 was found approximately two miles away from the facility by a local law enforcement officer and staff were unaware of the elopement until 7:45 PM when the resident was brought back to the facility. Staff 2 stated, she/he picked a time that was a good time when all the staff were busy.</p> <p>On 9/5/24 at 2:05 PM, Staff 1 (Administrator) and Staff 2 (DNS) were notified of the Immediate Jeopardy (IJ) situation and provided a copy of the IJ template related to the facility's failure to put into place individualized care plan interventions and to follow the residents care plan to prevent elopement.</p> <p>On 9/5/24 at 4:17 PM, an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions:</p> <ul style="list-style-type: none"> *Current residents identified as elopement risks would have their care plans reviewed to reflect person centered care. *All current residents would be reassessed for risk of elopement. Any identified residents' plan of care would be updated to include individualized, personalized interventions. *The elopement book would be updated to include any newly identified residents. *All facility staff would be educated on the residents identified at risk for elopement and their individualized care plan interventions as well as procedures to initiate if a resident eloped. Education would be completed by 9/6/24 at 2:30 PM. Staff who were on leave or under COVID restrictions would be required to complete the education prior to returning work. *Daily audits would be completed starting 9/6/24 by the Interdisciplinary Team (IDT) to ensure residents were properly identified for elopement risk, elopement care plans were individualized, and staff followed care plan elopement interventions. Any identified issues would be immediately corrected. *Daily audits would continue for 14 days, then weekly for three months. Results of the audits would be presented to the QAPI team. <p>The IJ was removed on 9/6/24 at 2:00 PM, as confirmed by onsite verification by the survey team on 9/9/24.</p>		