STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385138	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilot Butte Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined the facility failed to protect the residents' right to be free from verbal abuse by another resident for 4 of 5 sampled residents (#s 15, 16, 18, and 19) reviewed for verbal abuse. This placed residents at risk for further abuse. Findings include:1. Resident 15 was admitted to the facility in 12/2024 with diagnoses including depression and muscle wasting. Resident 17 was admitted to the facility in 12/2025 with diagnoses including traumatic brain injury, brain damage and adjustment disorder. Resident 15's Annual MDS dated [DATE] indicated she/he was cognitively intact. Resident 17's admission MDS dated [DATE] indicated she/he was moderately cognitively impaired. A Grievance Form dated 2/3/26 documented Resident 15 had been verbally abused by Resident 17. Resident 17 had called Resident 15 pussy and faggots and making threats. The form noted Resident 17 denied name-calling and threats and had been advised to request a staff member when upset. Further documentation indicated Resident 17 had improved and that lashing out had decreased. Recommended actions included continued monitoring. Resident 17's Care Plan dated 3/18/26 documented a risk for behavior symptoms including outbursts of yelling and cursing when redirected or educated. Interventions included approaching resident in a calm manner, reapproaching later if agitated or uncooperative, and keeping Resident 17 in a supervised area when out of bed. On 6/15/26 at 1:34 PM, Resident 15 stated Resident 17 cursed at her/him about once a month. Resident 15 stated the cursing did not make her/him feel good and made her/him uncomfortable. Resident 15 also stated the verbal behavior made her/him feel uncomfortable when directed at staff. On 6/23/26 at 8:12 AM, Staff 35 (CNA) stated on 2/3/26 Resident 17 said a lot of nasty things and had cursed at Resident 15. Staff 35 stated Resident 17 was so loud the whole facility knew what was happening and attempts had been made to stop the resident.On 6/24/26 at 10:09 AM, Staff 16 (Social Services Director) stated she followed up with Resident 15 about her/his grievance concern and educated Resident 15 about Resident 17's difficulty controlling verbal outburst. Staff 16 stated she did not have an opinion on whether the 2/3/26 incident constituted verbal abuse and stated it would depend on the residents' feelings. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated Resident 17 had been vocal in public spaces and directed verbal interactions toward staff rather than residents. Residents had become upset and had complained about Resident 17. Staff 1 stated residents who were interviewed did not indicate they had been verbally abused by Resident 17. 2. Resident 16 was admitted to the facility in 8/2022 with diagnoses including stroke. Resident 17 was admitted to the facility in 12/2025 with diagnoses including traumatic brain injury, brain damage and adjustment disorder. Resident 16's MDS dated [DATE] indicated she/he was cognitively intact. Resident 17's admission MDS dated [DATE] indicated she/he was moderately cognitively impaired. A Grievance Form dated 2/3/26 documented Resident 17 had verbally abused Resident 16, calling her/him pussy and faggots and making threats. Resident 17 denied name-calling and threats and had been advised to request a staff member when upset. Further documentation indicated Resident 17 had improved and that lashing out had decreased. Recommended actions included continued monitoring. Resident 17's Care Plan dated 3/18/26 documented she/he was at risk for behavior symptoms with (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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verbal outbursts of yelling and cussing when Resident 17 was redirected or educated. Interventions included approach resident in a calm manner, re-approach later if agitated or uncooperative. Resident 17 was to be in a supervised area when out of bed. On 6/15/26 at 1:26 PM, Resident 16 stated Resident 17 had threatened to attack her/him. Resident 17 called her/him derogatory statements. Resident 16 stated it pisses her/him off because it brought up bad memories from childhood. On 6/23/26 at 8:12 AM, Staff 35 (CNA) stated on 2/3/26 Resident 17 said a lot of nasty things and had cursed at Resident 16. Staff 35 stated Resident 17 was so loud the whole facility knew what was happening and attempts had been made to stop the resident. On 6/24/26 at 10:09 AM, Staff 16 (Social Services Director) stated she followed up with Resident 16 about her/his grievance concern and educated Resident 16 about Resident 17's difficulty controlling verbal outburst. Staff 16 stated she did not have an opinion on whether the 2/3/26 incident constituted verbal abuse and stated it would depend on the residents' feelings. On 6/24/26 at 11:43 AM Staff 1 (Administrator) stated Resident 17 had been vocal in public spaces and directed verbal interactions toward staff rather than residents. Residents had become upset and had complained about Resident 17. Staff 1 stated residents who were interviewed did not indicate they had been verbally abused by Resident 17. 3. Resident 18 was admitted to the facility in 9/2022 with diagnoses including stroke. Resident 17 was admitted to the facility in 12/2025 with diagnoses including traumatic brain injury, brain damage and adjustment disorder. Resident 17's admission MDS dated [DATE] indicated she/he was moderately cognitively impaired. Resident 18's MDS dated [DATE] indicated she/he was cognitively intact. A Grievance Form dated 3/13/26 documented Resident 18 was extremely uncomfortable due to Resident 17's actions. Resident 17 had been yelling curse words and vile names at residents and staff. The documented follow-up action was to continue educating, therapy and care planning for Resident 17. A Behavior Note dated 3/13/26 documented Resident 17 was upset about the dining room seating arrangement and had screamed homophobic slurs at residents and refused to calm down. Resident 17's Care Plan dated 3/18/26 documented she/he was at risk for behavior symptoms with verbal outbursts of yelling and cussing when Resident 17 was redirected or educated. Interventions included approach resident in a calm manner and re-approach later if agitated or uncooperative. Resident 17 was to be in a supervised area when out of bed. Resident 18's revised care plan documented the resident had declining health status, with interventions to include promoting a calm, quiet environment. A Behavior Note dated 6/13/26 documented Resident 17 had been kicking and screaming at residents and had called them names. On 6/17/26 at 8:09 AM, Resident 18 stated Resident 17 was verbally abusive. Resident 17 had told her/him I'm going to knock your ass, sometime in the second week of 6/2025. Resident 18 stated she/he had not felt safe in the facility due to Resident 17's behaviors. On 6/23/26 at 12:07 PM, Staff 43 (CNA) stated on 3/13/26, in the dining room with multiple residents present a resident had been placed in a seat where Resident 17 considered her/his spot. Staff 43 stated Resident 17 had yelled, you gay little faggot, at a resident. On 6/24/26 at 8:27 AM, Staff 15 (LPN) stated on 3/13/26 Resident 17 had been yelling at Resident 18 and another resident. Staff 15 did not recall specific words but stated Resident 17 had used many colorful words. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated Resident 17 had been vocal in public spaces and directed verbal interactions toward staff rather than residents. Residents had become upset and had complained about Resident 17. Staff 1 stated residents who were interviewed did not indicate they had been verbally abused by Resident 17. 4. Resident 19 was admitted to the facility in 7/2025 with diagnoses including depression and stroke. Resident 17 was admitted to the facility in 12/2025 with diagnoses including traumatic brain injury, brain damage and adjustment disorder. Resident 17's admission MDS dated [DATE] indicated she/he was moderately cognitively impaired. A Grievance Form dated 3/13/26 documented Staff 43 (CNA) had been advocating for Resident 19 due to verbal abuse from Resident 17. Resident 19 had been moved to different seating and had felt alienated from other resident because of being accused of taking Resident 17's dining room spot. Resident 19 had been tired of being called foul names. A separate Grievance Form dated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/13/26 documented Resident 17 had been screaming and yelling and had claimed Resident 19 took her/his spot. Resident 20 had been tired of seeing Resident 19 being insulted and bullied. A Behavior Note dated 3/13/26 documented Resident 17 had been upset about the dining room seating arrangement, screamed homophobic slurs at residents and refused to calm down. Resident 17's revised care plan dated 3/18/26 documented she/he was at risk for behavior symptoms with verbal outbursts of yelling and cussing when Resident 17 was redirected or educated. Interventions included approach resident in a calm manner, re-approach later if agitated or uncooperative. Resident 17 was to be in a supervised area when out of bed. Resident 19's Significant Change MDS dated [DATE] indicated she/he was severely cognitively impaired. On 6/17/26 at 8:11 AM, Witness 10 (Resident) stated she/he had heard Resident 17 calling Resident 19 a faggot. On 6/23/26 at 12:07 PM, Staff 43 confirmed she had completed the 3/13/26 grievance for Resident 19. Staff 43 stated Resident 17 entered the dining room and Resident 19 had been seated in a spot Resident 17 considered her/his own. Resident 17 stated to Resident 19, you gay little faggot. Staff 43 stated Resident 19 had been tearful. Staff 43 removed Resident 19 because attempting to remove Resident 17 would have escalated the situation. Resident 19 had been placed by the nurse's station outside the dining room, and she/he had appeared sad after leaving the dining room. Staff 43 stated she had not heard any response related to the outcome of the grievance. On 6/24/26 at 8:27 AM, Staff 15 (LPN) stated on 3/13/26 Resident 17 had been yelling at Resident 19 and another resident. Staff 15 did not remember specific words but stated Resident 17 used many colorful words. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated Resident 17 had been vocal in public spaces and directed verbal interactions toward staff rather than residents. Residents had become upset and had complained about Resident 17. Staff 1 stated residents who were interviewed did not indicate they had been verbally abused by Resident 17.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, it was determined the facility failed to ensure residents were free from misappropriation of property for 3 of 3 sampled residents (#s 8, 18, and 21) reviewed for misappropriation. This placed residents at risk for missed medications and an increase in pain. Findings include:1. Resident 8 was admitted to the facility in 2/2024 with diagnoses including complex pain syndrome and anxiety disorder. A 12/23/25 Narcotic Log (pg. 1) for Resident 8 indicated lorazepam 0.5 mg one tablet every two hours as needed for anxiety was ordered. Staff documented the medication was administered 11 times from 12/23/26 through 1/7/26 and Staff 3 (LPN) administered the medication 10 of those times. Resident 8's 12/2025 and 1/2026 MARs included lorazepam 0.5 mg, one tablet every two hours as needed for anxiety and oxycodone every four hours as needed for chronic pain. Staff documented the medication had been administered 11 times from 12/23/25 through 1/7/266, and Staff 3 administered the medication 10 of those times. Staff documented oxycodone had been administered 50 times from 12/23/26 through 1/7/26, and Staff 3 administered the medication 26 of those times. A Facility Reported Incident Form (FRI) dated 1/8/26 was submitted to the State Survey Agency, which alleged that Staff 3 (LPN) had administered narcotic medications to certain residents more frequently than other staff. An undated FRI Investigation included a review of facility narcotic logs, which indicated Staff 3 was the nurse who had administered narcotic medications and had not allowed the CMA to administer the narcotics. Staff 3 was suspended pending investigation and later resigned. Two CMAs reported concerns with Staff 3's behavior which included frantic disposal of medications which made confirmation of wasted medications difficult. Some residents asked for pain medications when documentation showed they had already received pain medications. During the audit it was noted an issue did occur related to the documentation of the disposal of medications and the facility could not account for medications within the narcotic log. On 6/22/26 at 9:46 AM, Staff 3 stated she would not provide a statement. On 6/23/26 at 11:42 AM, Staff 37 (CMA) stated a lot of medications were administered at night by Staff 3 and he was uncertain why a resident would need medication while they were sleeping. Staff 37 stated Resident 8 was administered lorazepam during the night and Resident 8 always slept through the night. On 6/23/26 at 10:46 AM, Staff 38 (CMA) stated she was the one who reported the concern. She had reported the concern around 11/2025, and an audit was completed and the concern continued so she reported the concern again. Staff 38 stated she was uncomfortable to count with Staff 3 because her behaviors were erratic. Staff 38 stated there were pages with an X on them but no documentation of where the medication was. She informed hospice because Resident 8 was an eight out of 10 pain and it was documented she/he was getting more medications at night but still in pain. On 6/24/26 at 11:35 AM, Staff 1 (Administrator) stated the facility had determined misappropriation of Resident 8's medications occurred. 2. Resident 18 was admitted to the facility in 2/2024 with diagnoses including phantom limb syndrome with pain. A Facility Reported Incident Form (FRI) dated 1/8/26 was submitted to the State Survey Agency, which alleged that Staff 3 (LPN) had administered narcotic medications to certain residents more frequently than other staff. A Medication Audit Reconciliation Narrative dated 1/13/26 documented all medication carts were audited and reconciled. All narcotic counts were reviewed and verified. During the audit two pages had been removed from the narcotic book and the corresponding medication cards for the entries could not be accounted for Resident 18's Percocet. An undated FRI Investigation included a review of facility narcotic logs, which indicated Staff 3 was the nurse who had administered narcotic medications and had not allowed the CMA to administer the narcotics. Staff 3 was suspended pending investigation and later resigned. Two CMAs reported concerns with Staff 3's behavior which included frantic disposal of medications which made confirmation of wasted medications difficult. Some residents asked for pain medications when documentation showed they had already received pain medications. During the audit it was noted an issue did occur related to the documentation of the disposal of medication and the facility could not (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	account for medications within the narcotic log. On 6/22/26 at 9:46 AM, Staff 3 stated she would not provide a statement. On 6/22/26 at 8:30 AM and 6/24/26 at 11:35 AM, Staff 1 (Administrator) stated the facility had determined misappropriation of Resident 18's medications. Resident 18 had two narcotic log pages torn out of the logbook and her/his Percocet medication was unaccounted for. 3. Resident 21 was admitted to the facility in 12/2025 with diagnoses including palliative care and chronic pain. A 12/2025 MAR indicated to administer morphine tablet every four hours for moderate to severe pain. On 12/25/25 Resident 21 was documented as having morphine administered four times with three of these times administered by Staff 3 (LPN). A Facility Reported Incident Form (FRI) dated 1/8/26 was submitted to the State Survey Agency, which alleged that Staff 3 (LPN) had administered narcotic medications to certain residents more frequently than other staff. A Medication Audit Reconciliation Narrative dated 1/13/26 documented all medication carts were audited and reconciled. All narcotic counts were reviewed and verified, during the audit two pages had been removed from the narcotic book and the corresponding medication cards for the entries could not be accounted for Resident 21's morphine. An undated FRI Investigation included a review of facility narcotic logs, which indicated Staff 3 was the nurse who had administered narcotic medications and had not allowed the CMA to administer the narcotics. Staff 3 was suspended pending investigation and later resigned. Two CMAs reported concerns with Staff 3's behavior which included frantic disposal of medications which made confirmation of wasted medications difficult. Some residents asked for pain medications when documentation showed they had already received pain medications. During the audit it was noted an issue did occur related to the documentation of the disposal of medication and the facility could not account for medications within the narcotic log. On 6/23/26 at 10:46 AM, Staff 38 (CMA) stated she was the one who reported the concern. She had reported the concern about around 11/2025, and an audit was completed and the concern continued so she reported again. Staff 38 stated she was uncomfortable to count with Staff 3 because her behaviors were erratic. A couple of morphine narcotic books were crossed out but no one had signed off on the medication for them to be destroyed. Staff 38 thought Staff 3 and Staff 37 had destroyed the medications. On 6/24/26 at 11:35 AM, Staff 1 (Administrator) stated the facility had determined misappropriation of Resident 21's medications. The deficient practice was identified as Past Noncompliance based on the following: On 1/18/26, the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and determined there was misappropriation of medications. The Plan of Correction included: 1. Staff educated on medication administration, medication count, disposal and storage of medications. 2. Police report placed for potential crime.3. Staff 3 resignation accepted.4. Pharmacy consulted to perform a medication cart audit.5. Narcotic audits to be completed weekly for four months, then monthly for three months. Audits would be brought to QAPI for review and education opportunities.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review it was determined the facility failed to report to the State Survey Agency an allegation of verbal abuse for 4 of 5 sampled residents (#s 15, 16, 18, and 19) reviewed for verbal abuse. This placed residents at risk for continued abuse. Findings include:1. Resident 15 was admitted to the facility in 12/2024 with diagnoses including depression and muscle wasting. A 2/3/26 Grievance Form documented Resident 15 was verbally abused by Resident 17 and was called pussy and faggots. Resident 17 also threatened physical assault to Resident 15. There was no documented evidence Resident 15's report of being verbally abused by Resident 17 was reported to the State Survey Agency for the incident on 2/3/26. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated she did not feel the allegation of verbal abuse rose to the level to report to the State Agency. 2. Resident 16 was admitted to the facility in 8/2022 with diagnoses including stroke. A 2/3/26 Grievance Form documented Resident 16 was verbally abused by Resident 17 and was called pussy and faggots. There was no documented evidence Resident 16's report of being verbally abused by Resident 17 was reported to the State Survey Agency for the incident on 2/3/26. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated she did not feel the allegation of verbal abuse rose to the level to report to the State Agency. 3. Resident 18 was admitted to the facility in 9/2022 with diagnoses including stroke. A 3/13/26 Grievance Form documented Resident 18 was extremely uncomfortable by Resident 17's actions. Resident 17 was yelling curse words and vile names at residents and staff. A Behavior Note dated 3/13/26 documented Resident 17 was upset about the seating arrangement in the dining room. Resident 17 screamed homophobic slurs at other residents and refused to calm down. On 6/24/26 at 8:27 AM, Staff 15 (LPN) stated on 3/13/26 Resident 17 was yelling at Resident 18 and another resident. Staff 15 did not remember specific words but stated Resident 17 used many colorful words. There was no documented evidence Resident 18's report of being verbally abused by Resident 17 was reported to the State Survey Agency for the incident on 3/13/26. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated she did not feel the allegation of verbal abuse rose to the level to report to the State Agency. 4. Resident 19 was admitted to the facility in 7/2025 with diagnoses including depression and stroke. A Grievance Form dated 3/13/26 documented Staff 43 (CNA) had been advocating for Resident 19 due to being verbally abused by Resident 17. Resident 19 had been tired of being called foul names. On 6/23/26 at 12:07 PM, Staff 43 stated Resident 17 called Resident 19 a gay little faggot. There was no documented evidence the 3/13/26 Grievance Report of Resident 19 being verbally abused by Resident 17 was reported to the State Survey Agency. On 6/24/26 at 11:43 AM. Staff 1 (Administrator) stated she did not feel the allegation of verbal abuse rose to the level to report to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review it was determined the facility failed to investigate allegations of verbal abuse for 4 of 5 sampled residents (#s 15, 16, 18, and 19) reviewed for verbal abuse. This placed residents at risk for further abuse. Findings include:1. Resident 15 was admitted to the facility in 12/2024 with diagnoses including depression and muscle wasting. A Grievance Form dated 2/3/26 documented Resident 15 had been verbally abused by Resident 17. Resident 17 had called Resident 15 pussy and faggots and making threats. The form noted Resident 17 denied name-calling and threats and had been advised to request a staff member when upset. Further documentation indicated Resident 17 had improved and that lashing out had decreased. There was no documented evidence the facility conducted a thorough investigation to determine whether verbal abuse had occurred. On 6/24/26 at 10:09 AM Staff 16 (Social Services Director) stated no formal investigation was completed. On 6/24/26 at 11:43 AM Staff 1 (Administrator) stated when the facility received a resident grievance form, interviews should be conducted with both staff and residents and document the information on a progress note or on the grievance form. Staff 1 provided no additional information to show a thorough investigation had been completed. 2. Resident 16 was admitted to the facility in 8/2022 with diagnoses including stroke. A Grievance Form dated 2/3/26 documented Resident 17 had verbally abused Resident 16, calling her/him pussy and faggots and making threats. Resident 17 denied name-calling and threats and had been advised to request a staff member when upset. Further documentation indicated Resident 17 had improved and lashing out had decreased. Recommended actions included continued monitoring. There was no documented evidence the facility conducted a thorough investigation to determine whether verbal abuse had occurred. On 6/24/26 at 10:09 AM, Staff 16 (Social Services Director) stated no formal investigation was completed. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated when the facility received a resident grievance form, interviews should be conducted with both staff and residents and document the information on a progress note or on the grievance form. Staff 1 provided no additional information to show a thorough investigation had been completed. 3. Resident 18 was admitted to the facility in 9/2022 with diagnoses including stroke. A Grievance Form dated 3/13/26 documented Resident 18 was extremely uncomfortable due to Resident 17's actions. Resident 17 had been yelling curse words and vile names at residents and staff. The documented action had been to continue education and therapy and complete care planning for Resident 17. A Behavior Note dated 3/13/26 documented Resident 17 was upset about the dining room seating arrangement and had screamed homophobic slurs at residents and refused to calm down. On 6/23/26 at 12:07 PM, Staff 43 (CNA) stated she had not heard anything from administration related to the grievance. There was no documented evidence the facility conducted a thorough investigation to determine whether verbal abuse had occurred. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated when the facility received a resident grievance form, interviews should be conducted with both staff and residents and document the information on a progress note or on the grievance form. Staff 1 provided no additional information to show a thorough investigation had been completed. 4. Resident 19 was admitted to the facility in 7/2025 with diagnoses including depression and stroke. A Grievance Form dated 3/13/26 documented Staff 43 (CNA) had been advocating for Resident 19 due to verbal abuse from Resident 17. Resident 19 had been moved to different seating and had felt alienated from other resident because of being accused of taking Resident 17's dining room spot. Resident 19 had been tired of being called foul names. A separate Grievance Form dated 3/13/26 documented Resident 17 had been screaming and yelling and had claimed Resident 19 took her/his spot. Resident 20 had been tired of seeing Resident 19 being insulted and bullied. A Behavior Note dated 3/13/26 documented Resident 17 had been upset about the dining room seating arrangement, screamed homophobic slurs at residents and refused to calm down. On 6/17/26 at 8:11 AM, Witness 10 (anonymous resident) stated she/he had heard Resident 17 calling Resident 19 a faggot. There was no documented evidence the facility conducted a thorough investigation to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	determine whether verbal abuse had occurred. On 6/23/26 at 12:07 PM, Staff 43 confirmed she had completed the 3/13/26 grievance for Resident 19. Staff 43 stated Resident 17 entered the dining room and saw Resident 19 was seated in a spot Resident 17 considered her/his own. Resident 17 called Resident 19, a gay little faggot. Staff 43 stated Resident 19 had been tearful. Staff 43 stated she had not heard any response related to the outcome of the grievance. On 6/24/26 at 11:43 AM, Staff 1 (Administrator) stated when the facility received a resident grievance form, interviews should be conducted with both staff and residents and document the information on a progress note or on the grievance form. Staff 1 provided no additional information to show a thorough investigation had been completed.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure community resources were in place for a safe and orderly discharge for 1 of 3 sampled residents (#4) reviewed for discharge. This placed residents at risk for an unsafe discharge. Findings include:Resident 4 was admitted to the facility in 1/2026 with diagnoses including mild cognitive impairment and second-degree burns to lower limbs. a. Resident 4's Care Plan dated 1/30/26 indicated the discharge destination was a shelter, noting she/he had been homeless. Interventions included planning with community resources to support independence post-discharge. A Social Services Note dated 4/1/26 documented Resident 4 had been informed that her/his discharge plan was unsafe, that the resident understood, and the resident was her/his own responsible party and had chosen to proceed. A Discharge summary dated [DATE] indicated reason for Resident 4's discharge was Medicaid had been denied and that Resident 4 had been discharged to houseless. It documented multiple discussions regarding safety concerns and noted Resident 4's continued intention to live in her/his vehicle. A home care referral was completed, and services would include physical, occupational, and speech therapy. A Discharge Summary MDS dated [DATE] indicated Resident 4 was cognitively intact and required supervision or touching assistance with walking 10 feet. There was no documented evidence in Resident 4's clinical record that a home health care referral was completed as indicated in the Discharge Summary. A Physical Therapy Discharge Summary signed 4/3/26 documented Resident 4 would ambulate 200 feet over uneven pavement using a front wheel walker with modified independent. On 3/20/24 Resident 4 completed 200 feet two times over uneven pavement with a front-wheel walker and stand by assistance. At the time of therapy discharge on [DATE], testing Resident 4's ability to ambulate 200 feet over uneven pavement was not completed prior to discharge. On 4/6/26 the State Survey agency received a complaint indicating Resident 4 had admitted to the facility for burns sustained to her/his legs from a propane heater living in her/his vehicle. The resident discharged back to her/his truck and fell and sustained a spine fracture and skull fracture. A 4/13/26 hospital Discharge Summary indicated Resident 4 was admitted to the hospital on [DATE] with a shattered neck break, closed fracture of the forehead and closed fracture to odontoid (small bony peg on the second neck bone to help turn the head side to side.) Resident 4 was found on the ground outside of her/his vehicle on 4/3/26. On 6/16/26 at 10:51 AM and on 6/17/26 at 7:58 AM, attempts to contact Resident 4 were unsuccessful. On 6/18/26 at 8:47 AM, Witness 9 (Transitional Care Advisor for Home Health Care) stated no home health services referral was received for Resident 4's 4/2/26 discharge. On 6/24/26 at 10:00 AM, Staff 16 (Social Services Director) stated usually emails would go back and forth for home health services referrals. Staff 16 stated Resident 4 was questioned about moving into her/his vehicle and Resident 4 had the right to make bad choices and it was not in her control. No email exchanges with home health were provided. On 6/24/26 at 11:25 AM, Staff 1 (Administrator) stated if a discharge summary indicated a resident was referred to home health services, she would expect the referral to be placed. Resident 4 was admitted to the facility in 1/2026 with diagnoses including displaced fracture of second cervical vertebra, fracture of vault of skull, and fracture of the neck. b. A 4/17/26 admission MDS indicated Resident 4 was moderately cognitively impaired. A 5/24/26 Physician Communication form from Staff 25 (RN) to the physician documented Resident 4 wished to discharge because of money concerns. Staff 25 documented that Resident 4 did not appear cognitively able to live independently and had confusion. A physician response dated 5/27/26 indicated Resident 4 discharged before she/he could be seen and Resident 4 left against medical advice. The physician had told Resident 4 not to discharge until she/he was cleared by neurosurgery. A 5/25/26 Physician Progress note indicated Resident 4 was upset and wanted to leave against medical advice. Resident 4 did not have a safe (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385138	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilot Butte Rehabilitation Center	1876 NE Highway 20 Bend, OR 97701

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge plan and appeared confused intermittently during discussion. Resident 4 had a history of mild cognitive impairment. It was recommended Resident 4 stay at the facility until she/he was cleared by the neurosurgeon rather than leaving the facility against medical advice. There was no documented evidence in Resident 4's clinical record that she/he signed leaving the facility against medical advice or a referral for home health services was completed. A 5/26/26 Discharge Summary documented anticipated discharge date was 5/27/26 and was a resident driven discharge. Discharge was to a business parking lot. Resident 4 was a fall risk and no longer wished to move forward with liquidating assets to obtain Medicaid. Resident 4 was aware that it meant she/he had to discharge from the facility. Functional level of status was toileting hygiene maximal assistance of one-person and moderate assistance of one person for bathing and dressing. Home care equipment none, home care referral was completed for physical and occupational therapy. Resident 4 would follow up on her/his own for future appointments. A 5/27/26 Discharge Notice and Order Request indicated Resident 4 needed physical and occupational therapy. Nursing and social services were needed. Additional nursing instructions were for neck brace management and medication management. On 6/16/26 at 10:51 AM and on 6/17/26 at 7:58 AM, attempts to contact Resident 4 were unsuccessful. On 6/16/26 at 12:01 PM, Witness 8 (Friend) stated Resident 4 was confused and her/his mind is not at all there. Witness 8 stated Resident 4 was living in an RV park and a person who works at the park had checked in with her/him. On 6/18/26 at 8:47 AM, Witness 9 (Transitional Care Advisor for Home Health Care) stated no home health services referral was received for Resident 4's 5/27/26 discharge. Witness 9 stated a medical agency had reached out to her not the facility. Witness 9 stated she personally never spoke with Resident 4. On 6/17/26 at 8:47 AM, on 6/18/26 at 9:43 AM, and on 6/24/26 at 11:25 AM, Staff 1 (Administrator) stated if a discharge summary indicated a resident was referred to home health services, she would expect the referral to be placed. Staff 1 stated Staff 16 (Social Services Director) was unavailable during Resident 4's second discharge and Staff 1 did not document notes. Staff 1 stated Resident 4 did not want to get rid of her/his assets. Witness 8 had informed her that Resident 4 would be on Witness 8's property in a fifth wheel trailer. Staff 1 stated Resident 4 did not discharge against medical advice, and it was a coordinated discharge with the physician.