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	05/31/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 47001 Based on interview, and record review it was determined the facility failed to obtain consent to administer medication for 1 of 5 (#16) sampled residents reviewed for unnecessary medications. This placed residents at risk for uninformed care. Findings include: Resident 16 admitted to the facility in 12/2019 with diagnoses including dementia, restlessness and agitation. A review of Resident 16's Physician Orders revealed an 4/11/24 order for buspirone (a medication in the anxiolytic drug class used to treat anxiety). A review of Resident 16's medical record revealed an 4/11/24 signed consent for buspirone listed as an antidepressant medication. The consent went over the risks and benefits for an antidepressant medication. On 5/30/24 at 4:03 PM Staff 2 (DNS) stated buspirone was an anxiolytic medication, not an antidepressant medication. Staff 2 acknowledged Resident 16 and her/his representative were not given informed consent for buspirone.

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
	385138	A. Building B. Wing	05/31/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 41455 Based on interview and record review it was determined the facility failed to evaluate a resident's choice for bathing for 1 of 1 sampled resident (#18) reviewed for choices. This place residents at risk for lack of honored choices. Findings include: Resident 18 admitted to the facility in 2023 with diagnoses including stroke and anxiety. The 3/4/24 Quarterly MDS indicated Resident 18 required partial to moderate assistance for bathing and was cognitively intact. A 11/29/24 care plan indicated to provide Residents 18's bathing according to his/her preferences two times a week. The Task: Shower form for Resident 18 indicated the following: -On 5/1/24 at 9:30 PM the resident refused her/his shower. -On 5/4/24 at 8:30 PM the resident refused her/his shower. -On 5/11/24 at 9:54 PM the resident refused her/his shower. On 5/28/24 at 9:23 AM Resident 18 stated she/he refused showers because staff offered showers at night when she/he wanted to be in bed. Resident 18 stated she was told by CNAs her/his showers were scheduled at night. Resident 18 requested a different time for bathing and no changes were made to her/his bathing schedule. On 5/29/24 at 8:39 AM Staff 5 (Resident Care Manager) stated an investigation regarding Resident 18's shower refusals was not started as expected. Staff 5 acknowledged Resident 18 should be aware an alternative shower schedule was available.

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	05/31/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 26991 Based on interview and record review it was determined the facility failed to ensure advance directive information was provided to residents for 3 of 4 sampled residents (#s 11, 34, and 40) reviewed for advance directives. This placed residents at risk for lack of end-of-life choices being honored. Findings include: 1. Resident 11 admitted to the facility in 2023 with a diagnosis of surgical infection. An 4/6/24 quarterly MDS revealed Resident 11 had impaired cognition. An 4/11/24 Care Conference form indicated Resident 11 had an advance directive. On 5/29/24 at 10:01 AM Staff 9 (Social Service Director) stated if the Care Conference form indicated the resident had an advance directive, a copy was to be in the resident's clinical record. On 5/29/24 at 2:18 PM Staff 2 (DNS) stated Resident 11 did not have an advance directive. Staff 2 also stated there was no documentation to indicate Resident 11 or her/his representative were provided information regarding advance directives. On 5/29/24 at 2:50 PM Witness 3 (Family) and Witness 4 (Family) stated the facility did not provide information related to advance directives. Witness 3 also stated he did not know anything about advance directives. 2. Resident 34 admitted to the facility in 2024 with a diagnosis of skin infection. A 5/7/24 quarterly MDS revealed Resident 34 was cognitively intact. A 5/23/24 Care Conference form indicated Resident 34 had an advance directive. On 5/29/24 at 8:08 AM Resident 34 stated she/he did not have an advance directive, did not want and advance directive, and the facility did not provide information related to advance directives. On 5/29/24 at 9:53 AM Staff 9 (Social Service Director) stated Resident 34 did not have an advance directive in her/his clinical record and would provide documentation if advance directive information was provided. No additional information was provided. 3. Resident 40 admitted to the facility in 2024 with a diagnosis of UTI. A 5/10/24 admission MDS revealed Resident 40 was cognitively intact. A 5/20/24 Care Conference form revealed Resident 40 had an advance directive. On 5/29/24 at 9:46 AM Resident 40 stated she/he did not have an advance directive and the facility did not provide information regarding advance directives. (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	05/31/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 9:50 AM Staff 9 (Social Service Director) stated if the record indicated a resident had an advance directive it should be in the resident's clinical record. A request was made to Staff 9 to provide Resident 40's advance directive or documentation to indicate advance directive information was provided. No additional information was provided.

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	05/31/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47001 Based on interview and record review it was determined the facility failed to provide an Advanced Beneficiary Notice for 1 of 3 (#5) sampled residents reviewed for Beneficiary Notification. This placed residents at risk for financial loss. Findings include: Resident 5 admitted to the facility in 8/2016 with diagnoses including respiratory failure. Resident 5 had a skilled Medicare stay from 1/10/23 through 1/19/23. Resident 5 remained in the facility after 1/19/23 on Medicaid. A review of Resident 5's medical record revealed no evidence of an Advanced Beneficiary Notice (ABN) issued to her/him after his Medicare stay. On 5/31/24 at 9:08 AM Staff 3 (Regional Nurse Consultant) acknowledged Resident 5 was not issued an ABN upon payor change from Medicare to Medicaid on 1/19/23.

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	05/31/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34703 Based on observation and interview it was determined the facility failed to maintain comfortable temperature levels for 1 of 2 (Pine Meadow Hall) halls observed for environment. This placed residents at risk for uncomfortable temperatures. Findings include: Resident 26 admitted to the facility in 2024 with diagnoses including ALS (a nervous system disease). On 5/28/24 at 10:17 AM Resident 26 stated her/his room and the hall were too cold and made her/his body hurt. Resident 26 stated she/he reported this to management and nursing staff, but nothing was done to resolve the temperature issue. On 5/30/24 at 10:39 AM Staff 15 (CNA) and Staff 16 (CNA) stated Pine Meadow Hall was cold and residents complained about it. Multiple random observations from 5/28/24 through 5/31/24 revealed Resident 26's room and Pine Meadow Hall were cold. The thermostat for the hall was set to 68 degrees. On 5/30/24 at 1:04 PM Staff 14 (Maintenance Director) stated he tested the temperature in residents' rooms but did not document the results or complete audits. Staff 14 stated he was aware of Resident 26's complaints of being cold, but he kept the thermostats at 74 degrees. On 5/30/24 at 1:10 PM Staff 2 (DNS) verified the thermostat in Pine Meadow Hall was set for 68 degrees and should be set for 71 degrees to 81 degrees to keep residents comfortable, and acknowledged she was aware Resident 26 complained of the hall and her/his room being cold.

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	05/31/2024

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41455 Based on interview and record review it was the determined the facility failed to prevent abuse for 3 of 3 (#s 14, 21, and 31) sampled residents reviewed for abuse. This placed residents at risk for abuse. Findings include: 1. Resident 14 admitted to the facility in 2022 with diagnosis including stroke. A 3/5/24 Quarterly MDS revealed Resident 14 was cognitively intact. A 3/27/24 revised care plan indicated Resident 14 was incontinent of bowel and required one staff to assist with bowel care. A 5/14/24 Alleged Abuse investigation for Resident 14 indicated a CNA reported an allegation of abuse because Resident 14 was questioned why she/he no longer had Staff 23 (former Agency CNA) provide her/his care. Resident 14 stated Staff 23 completed her/his personal care and wiped her/him roughly stating Staff 23 tried to stick a wipe and her finger up her/his butt. Resident 14 told Staff 23 she was rough during care. Resident 14 indicated Staff 23 continued to provide rough care, became upset and told her/him not to tell her how to complete her job. On 5/28/24 at 1:33 PM Resident 14 confirmed she/he told Staff 23 to stop and she kept going during personal care after her/his bowel movement. On 5/31/24 at 1:16 PM Staff 1 (Administrator) acknowledged the facility investigation revealed abuse occurred between Staff 23 and Resident 14. 47001 2. Resident 21 admitted to the facility in 8/2023 with diagnoses including spinal stenosis (a narrowing of the spinal canal which can cause pressure on the spinal cord of nerves). A 2/25/24 Quarterly MDS revealed Resident 21 was cognitively intact. A 5/14/24 Incident Reported revealed Resident 21 reported Staff 23 (former agency CNA) was verbally rude and was rough with care. On 5/14/24 a FRI form was submitted to the State Agency by the facility. On 5/28/24 at 8:49 AM Resident 21 stated Staff 23 was verbally abusive and was rough with care. Resident 21 stated she/he asked Staff 23 to be gentle with care, but she was not. On 5/30/24 at 5:31 PM Staff 23 stated she encouraged Resident 21 to be more independent and Resident 21 became mad at her. (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	05/31/2024

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 - Few	On 5/31/24 at 8:46 AM Staff 2 (DNS) stated Resident 21 had a skin assessment completed after the allegation, no physical injuries were noted. Staff 2 stated Resident 21 was placed on alert charting after the allegation to monitor for psychosocial harm, and no psychosocial harm was noted. On 5/31/23 at 1:37 PM Staff 1 (Administrator) confirmed the investigation for the allegation of abuse concluded Staff 23 was abusive toward Resident 21. 3. Resident 31 admitted to the facility in 1/2024 with diagnoses including hemiplegia (paralysis of half of the body) affecting the left side of the body. A 5/5/24 Quarterly MDS revealed Resident 31 was cognitively intact. A 5/14/24 Incident Report revealed Resident 31 reported Staff 23 (former agency CNA) was emotionally and physically abusive. On 5/14/24 a FRI form was submitted to the State Agency by the facility. On 5/28/24 at 9:55 AM Resident 31 stated Staff 23 called her/him a liar when Resident 31 stated she/he needed to be put back in bed. Resident 31 stated it took three hours for Staff 23 to put her/him back in bed. Resident 31 stated once Staff 23 put her/him in bed, she changed her/his incontinent brief. Resident 31 stated Staff 23 jerked her/him around like a rag doll, and shoved her/him into the wall. Resident 31 stated she/he requested Staff 23 be careful and Staff 23 replied I have 40 some patient here, if I took time to turn them all carefully, I would not be able to do my job. On 5/30/24 at 5:31 PM Staff 23 stated Resident 31 wanted to lay down right after lunch, she/he was a two-person transfer and she was not able to lay her/him down right away, and Resident 31 became angry with her. On 5/31/23 at 8:46 AM Staff 2 (DNS) stated Resident 31 had a skin assessment completed after the allegation, and no physical injuries were noted. Staff 2 stated Resident 31 was placed on alert charting after the allegation to monitor for psychosocial harm, and no psychosocial harm was noted. On 5/31/23 at 1:37 PM Staff 1 (Administrator) confirmed the investigation for the allegation of abuse concluded Staff 23 was abusive toward Resident 31.

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	05/31/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41455 Based on interview and record review it was determined the facility failed to revise care plans for 2 of 5 sampled residents (#s 2 and 34) reviewed for unnecessary medications. This placed residents at risk for lack of appropriate care. Findings include: 1. Resident 2 admitted to the facility in 2024 with diagnoses including end stage kidney disease and stroke. A 5/24/24 hospital Discharge Summary indicated Resident 2 admitted to the hospital due to a hematoma (pool of mostly clotted blood) in her/his chest wall while on an oral anticoagulant. Resident 2's discharge medications included no anticoagulant medication. A 5/24/24 revised care plan indicated to provide interventions, monitor and prevent bleeding for Resident 2 due to the use of her/his anticoagulant medication. On 5/31/24 at 9:22 AM Staff 5 (Resident Care Manager) stated the orders for Resident 2 were not checked twice as expected when Resident 2's anticoagulant medication was discontinued. Staff 5 acknowledged Resident 2's care plan was not revised. 26991 2. Resident 34 admitted to the facility in 2024 with a diagnosis of dementia. Resident 34's clinical record revealed she/he was started on Ativan (antianxiety medication) during 3/2024. A Care Plan revised on 3/12/24 revealed Resident 34 was at risk for side affects of Ativan. The Care Plan did not include what caused Resident 34 to be anxious or resident specific interventions to provide prior to the administration of Atvian. On 5/30/24 at 3:03 PM Staff 5 (Resident Care Manager) stated after Resident 34's Atvian was initiated a care plan was not updated to include resident specific behaviors or interventions for the use of Ativan. Refer to F758.

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	05/31/2024

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 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** 34703 Based on interview and record review it was determined the facility failed to follow physician orders for 2 of 2 sampled residents (#s 7 and 9) reviewed for accidents and hospice. This placed residents at risk for unmet care needs. Findings include: Resident 9 admitted to the facility in 2017 with diagnoses including end of life care and restless leg syndrome. An 10/10/23 Cognitive Loss CAA revealed Resident 9 stated rest, repositioning and medications were helpful to address her/his pain relief and discomfort. The 11/2/23 physician order indicated Resident 9 was to receive Benztropine (restless leg medication) every evening at bedtime. A review of Resident 9's clinical record for 5/2023 revealed Resident 9 missed eight doses of her/his Benztropine. On 5/28/24 at 8:20 AM Resident 9 stated she/he went without the medication she needed for her/his restless leg syndrome for eight days. On 5/29/23 at 3:38 PM Staff 2 (DNS) acknowledged the resident missed eight doses of her/his medication. 47001 2. Resident 7 admitted to the facility in 2/2024 with diagnoses including depression. A 5/21/24 MDS indicated Resident 7 had moderate cognitive impairment. A 5/22/24 Progress Note revealed Resident 7 felt unsafe with the resident in room [ROOM NUMBER]A near her/him and measures were put in place to keep Resident 7 safe. A 5/23/24 care plan indicated Resident 7 and the resident in room [ROOM NUMBER]A were not to have contact with each other per Resident 7's preference. On 5/29/24 at 12:25 PM Staff 9 (Social Service Director) stated the resident in room [ROOM NUMBER]A was Resident 33 and was not in room [ROOM NUMBER]A anymore. On 5/29/24 at 4:51 PM Resident 7 stated she/he was uncomfortable with Resident 33 because she/he sat too close to her/him and Resident 7 stated Resident 33 was wacky. On 5/30/23 at 12:26 PM Resident 7 was observed in the dining room and Resident 33 was observed pulling up a chair and sitting next to Resident 7. Staff in the dining room did not intervene. At 12:31 PM Staff 9 (Social Service Director) was informed of the observation by the surveyor. Staff 9 spoke with a staff member in the dining room and Resident 33 was moved to another table. (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	05/31/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 1:45 PM Staff 1 (Administrator) and Staff 2 (DNS) confirmed Resident 7 was care planned to not have contact with Resident 33 and acknowledged ongoing training was needed. Staff 2 acknowledged Resident 7's care plan was not updated after Resident 33 moved out of room [ROOM NUMBER]A.

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	05/31/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 47001 Based on interview and record review it was determined the facility failed to scheduled an audiology exam for 1 of 1 sampled resident (#22) reviewed for communication needs. This placed residents at risk for unmet needs. Findings include: Resident 22 admitted to the facility in 4/2023 with diagnoses including a stroke. A 1/24/24 Provider Progress Note revealed Resident 22 requested to see a hearing doctor. An 4/27/24 MDS revealed Resident 22 was cognitively intact. On 5/28/24 at 9:48 AM Resident 22 stated she/he was hard of hearing and was recommended hearing aids at a doctor's appointment approximately eight months ago. On 5/29/24 at 12:21 PM Staff 9 (Social Service Director) stated Resident 22 should have had a hearing appointment set up but was unable to locate the information. A 5/29/24 Progress Note revealed Resident 22's son was called to confirm or schedule a yearly hearing exam for Resident 22. On 5/31/24 at 8:06 AM Staff 5 (RN Resident Care Manager) stated she was aware Resident 22 was hard of hearing and acknowledged Resident 22 did not see a hearing doctor.

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	05/31/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41455 Based on observation, interview and record review it was determined the facility failed to accurately assess pressure wounds and follow physician orders for 2 of 3 sampled residents (#s 4 and 19) reviewed for pressure ulcers. This placed resident at risk for worsening wounds. Findings include: 1. Resident 4 admitted to the facility in 2023 with diagnoses including stroke and aphasia (speech or language deficit due to brain injury). A 12/9/23 physician order indicated to float Resident 4's heels while in bed, apply skin prep to her/his heels each shift and ensure a foam boot was applied to her/his right heel at all times. The 4/19/24 Quarterly MDS indicated Resident 4 had a Stage 4 (deep wound that may impact muscles, ligaments, and bone) pressure ulcer to the heel. The 5/2024 TAR indicated on each shift through 5/29/24 Resident 4's heels were floated while in bed, skin prep was applied to her/his heels each shift and a foam boot was applied to her/his right heel at all times. The 5/22/24 revised care plan indicated to administer treatments as ordered and encourage Resident 4 to float her/his heels. On 5/29/24 at 12:06 PM Resident 4 was observed in bed with her/his heels resting on the bed and her/his feet exposed to the air. On 5/29/24 at 1:03 PM Staff 22 (CNA) stated she was not assigned to care for Resident 4 on 5/29/24, but confirmed her/his heels should be floated and boots applied to her/his feet. On 5/30/24 at 9:53 AM and 10:06 AM Staff 6 (LPN) stated Staff 26 (RN) changed Resident 2's treatments a week prior and Resident 2's feet were to remain exposed to the air. Staff 6 stated on 5/29/24 she did not verify Resident 2's heels were floated or was informed Resident 2 refused. On 5/30/24 at 10:00 AM Staff 16 (CNA) stated Resident 2 typically refused to float her/his heels and she did not inform nursing of the resident's refusal on 5/29/24. On 5/31/24 at 9:01 AM Staff 5 (Resident Care Manager) stated she was not informed of Resident 2's refusals to float her/his heels and acknowledged any changes to Resident 2's treatments should be updated in the resident's clinical record and followed. 34703 2. Resident 19 admitted to the facility in 2023 with diagnoses including bladder cancer. A 11/18/23 Incident Note indicated Resident 19 had an open area to the sacrum (triangular bone at the bottom of the spine) and discolored area approximately 2 cm x 1 cm on the right side of the gluteal cleft. (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	05/31/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 11/24/23 Incident Note indicated Resident 19 had a small approximately 0.2 cm open area with a very small unmeasurable purple spot on her/his sacrum at the intragluteal cleft. A 12/1/2023 Incident Note indicated Resident 19 was on alert related to an open area with a very small unmeasurable purple spot on her/his sacrum at intragluteal cleft. A 12/12/23 Skin and Wound Evaluation indicated Resident 19 had a Stage 4 (deep wound that may impact muscles, ligaments, and bone) wound to her/his coccyx (tail bone). A 12/14/23 Progress Note indicated Resident 19 had a small sacral pressure wound. The 12/2023 TAR indicated Resident 19 had a small sacral pressure wound. 12/5/23 and 1/5/24 physician orders indicated staff were to provide wound care to small sacral pressure wound. A 1/26/24 Skin and Wound Evaluation indicated Resident 19 had a Stage 4 in-house acquired pressure ulcer. There were no further Skin and Wound Evaluations until 3/1/24. On 5/31/24 at 11:22 AM Staff 5 (Resident Care Manager) acknowledged the wound was a deep tissue injury from the beginning and was not assessed accurately, and the TAR and the physician order were not accurate describing the wound as a small sacral wound. On 5/31/24 at 11:51 AM Staff 3 (Regional RN) stated staff assessed the wound inaccurately when the wound started. Staff 2 acknowledged from 1/26/24 to 3/1/24 there were no weekly Skin and Wound Evaluations completed.

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	05/31/2024

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 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. 47001 Based on observation, interview, and record review it was determined the facility failed to provide adequate supervision for 1 of 2 sampled residents (#33) reviewed for accidents. This placed residents at risk for injury. Findings include: Resident 22 admitted to the facility in 4/2024 with diagnoses including a stroke. An 4/5/24 MDS revealed Resident 33 had moderate cognitive impairment. A 5/15/24 Elopement Evaluation revealed Resident 33 was a moderate risk for elopement. A 5/29/24 review of Resident 33's care plan revealed no evidence of an elopement care plan. Resident 33 was observed during random observations from 5/28/24 through 5/31/24 to ambulate with a walker up and down the hallways, through the dining room, front lobby and occasionally resident rooms throughout the day. On 5/30/24 at 1:54 PM Staff 1 (Administrator) and Staff 2 (DNS) confirmed Resident 33 was at risk for elopement but was not care planned at risk for elopement.

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	05/31/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41455 Based on interview and record review it was determine the facility failed to implement orders and consistently monitor a dialysis (a procedure to remove excess waste products and fluid from the blood) access site for 1 of 1 sampled resident (#2) reviewed for dialysis. This placed residents at risk for dialysis complications. Findings include: Resident 2 admitted to the facility in 2024 with diagnoses including end stage kidney disease and stroke. A 3/4/24 Admission MDS indicated Resident 2 received dialysis. A 5/20/24 RD Nutrition Assessment indicated Resident 2 required an early breakfast and late lunch on dialysis days and to avoid high phosphorus and potassium food options at meals. A 5/21/24 Nursing Note indicated receipt of a new diet order for Resident 2 to avoid high phosphorus and potassium foods. A 5/24/24 revised care plan indicated to assess Resident 2's dialysis shunt for bruit (whooshing) and thrill (vibration) daily and provide diet according to orders. The 5/2024 TAR indicated no post-dialysis monitoring of bruit, thrill or pressure site dressing. On 5/28/24 at 2:09 PM Resident 2 stated she/he left for dialysis before breakfast in the mornings and did not return until late for lunch. Resident 2 stated she/he was provided no food until she/he returned from dialysis. On 5/29/24 at 1:32 PM Staff 2 (DNS) acknowledged the dialysis site should be monitored daily by nursing and food should be sent with Resident 2 to dialysis. On 5/29/24 at 2:53 PM Staff 4 (Dietary Manager) stated he was not aware Resident 2 required special meal accommodations due to dialysis and did not revise diet restrictions to address high potassium and phosphorus foods. On 5/29/24 at 3:50 PM Staff 13 (RD) acknowledged Resident 2's diet restriction should be on her/his meal ticket and the appropriate foods provided.

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	05/31/2024

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 26991 Based on interview and record review it was determined the facility failed to ensure a resident was assisted with discharge planning arrangements for 1 of 1 sampled resident (#11) reviewed for care planning. This placed residents at risk for increased anxiety. Findings include: Resident 11 admitted to the facility in 2023 with a diagnosis of surgical infection. Resident 11's clinical record revealed her/his home was six miles from the facility. A 12/8/23 Quarterly MDS revealed Resident 11 was able to answer questions but had moderate cognitive issues. A 1/10/24 Care Conference form revealed Witness 3 (Family) and Witness 4 (Family) attended the care conference. The form indicated Witness 3 and Witness 4 requested they be notified before Resident 11 was discharged to ensure they had things set up for the resident's care. The form indicated Resident 11 wanted to go home. Concerns related to the resident's discharge were the resident's mental status and weakness. The form did not indicate what needed to be set up at the resident's home to ensure it was ready for her/his care. An 4/11/24 Care Conference form revealed Resident 11's family had a meeting to discuss discharge and the plan was for Resident 11 to discharge home with caregivers. The form also indicated the Resident's family felt it was better for Resident 11 to return home. The family requested a home evaluation. The facility notified the family the resident needed 24/7 support. The form also indicated family would provide care, but did not specify who, if a home evaluation was to be completed, or what equipment or steps were needed to ensure a safe discharge. On 5/28/24 at 10:04 AM Resident 11 stated discharge planning was confusing. Resident 11 stated she/he should have been discharged on e month prior but no one at the facility communicated with her/him. A 5/28/24 Progress note revealed Resident 11 approached staff to inquire about her/his discharge home. Resident 11 requested staff call family. The note indicated Witness 4 reported they were waiting for the local unit to get things approved. On 5/29/24 at 12:06 PM Staff 7 (Therapy Director) stated Resident 11 exhausted her/his therapy benefits and was not eligible for additional therapy. Therapy ended 4/6/24. Staff 7 stated the resident did not improve with therapy and often did not want to get out of bed. Resident 11 would not be able to go home alone and Resident 11 reported she/he had a roommate. Staff 7 stated she was not sure who would provide care for Resident 11. Staff 7 stated therapy could do a home evaluation if the resident lived within 10 miles of the facility. Staff 11 was not sure the distance to Resident 11's home. Staff 7 stated caregiver training was not provided. (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	05/31/2024

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 12:06 PM and 5/30/24 at 11:46 AM Staff 9 (Social Service Director) stated the resident had a roommate at her his home but was not sure who lived with the resident. Staff 7 also stated the resident required a ramp to enter the home and did not provide information to the family related to resources. Staff 7 stated the family was waiting for the local unit to assist with the resident's financial status. Staff 7 stated she informed the family to call her if they needed help but thought the family did not want the resident to return home. Staff 7 stated she did not speak to the local unit. A request was made to provide documentation of assistance provided to the Resident 11's family to assist with the plan for her/his discharge. No additional information was provided. On 5/29/24 at 2:50 PM Witness 3 and Witness 4 stated therapy was to evaluate the home for the resident's discharge but it was not completed. Witness 3 stated they even called hospice to see if they could provide assistance with getting the resident home. Witness 3 and Witness 4 stated the facility never worked with them to assist with transfers or how to care for the resident. They lived with the resident and the resident wanted to go home. The facility did not help at all. On 5/29/24 at 3:37 PM Witness 5 (Local Unit) stated it was the facility responsibility to ensure the resident had all the needed equipment and supervision to go home. Resident 11 was just approved for financial assistance. Witness 5 stated the local unit could help with a ramp to the resident's home. Witness 5 stated the facility did not communicate with her/him regarding the resident's discharge or financial eligibility status.

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	05/31/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 26991 Based on interview and record review it was determined the facility failed to ensure non-pharmacological interventions were provided prior to PRN antianxiety medication administration for 1 of 5 sampled residents (#37). This placed residents at risk for sedation. Findings include: Resident 37 admitted to the facility in 2024 with a diagnosis of dementia. Resident 37's Care Plan was updated on 3/12/24 to indicate the resident was at risk for side affects of Ativan (antianxiety medication). A 5/2024 MAR revealed Resident 37 was to be administered Ativan PRN. The resident was administered Ativan 53 times. Only one time the medication was documented as not effective. 5/2024 progress note revealed Resident 37 had anxiety and PRN Ativan was administered. The Ativan was frequently administered at the same time as oxycodone (narcotic pain medication), therefore it was indeterminate if a decrease in the resident's pain level would have decreased her/his anxiety. The Progress notes did not describe how Resident 37's anxiety presented or what specific interventions were provided to decrease her/his anxiety. On 5/29/24 at 8:20 AM Staff 24 (CNA) stated at times Resident 37 was anxious because she/he had delusions (false belief of reality) and often did not remember she/he resided in the facility. Resident 37 usually wanted to be with her/his family. When able, staff called Resident 37's family which helped the resident's anxiety. If the resident had behaviors it was reported to the nurse. On 5/30/24 at 1:54 PM Staff 25 (LPN) stated if a PRN pscyhotropic medication was administered, staff were to document on the MAR or in the Progress Notes what the behavior was and what interventions were provided prior to administration. The MAR usually had interventions specific to the resident and staff could select the interventions provided. On 5/30/24 at 3:03 PM Staff 5 (Resident Care Manager) stated if a PRN antianxiety medication was to be administered staff were to identify the cause and provide interventions specific to the anxiety. Staff 5 stated Resident 37's anxiety improved after the resident became accustomed to the environment. A request was made to Staff 5 to provide documentation interventions specific to anxiety were provided. No additional information was provided.

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	05/31/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41455 Based on interview and record review it was determined the facility failed to ensure orders for a hypertensive medication were implemented for 1 of 5 sampled residents (#2) reviewed for medications. This placed residents at risk for abnormal heart rhythms. Findings include: Resident 2 admitted to the facility in 2024 with diagnoses including high blood pressure and end stage kidney disease. A 5/13/24 revised care plan indicated Resident 2 had altered cardiovascular status, to monitor vital signs, provide medications per physician order and report any abnormalities. A 5/24/24 hospital Discharge Summary indicated to continue Resident 2's metoprolol succinate (medication to control abnormal heart rhythms). The 5/2024 MAR indicated Resident 2's metoprolol succinate was last administered by the facility on 5/21/24. On 5/31/24 at 9:22 AM Staff 5 (Resident Care Manager) stated the orders for Resident 2 were not checked twice as expected when Resident 2 returned from the hospital (on 5/24/24). Staff 5 acknowledged Resident 2's metoprolol succinate was not administered as ordered.

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	05/31/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41455 Based on observation, interview, and record review it was determined the facility failed to provide therapeutic diets to 3 of 4 (#s 2, 23, and 28) sampled residents reviewed for food. This placed residents at risk for unmet nutritional needs. Findings include: 1. Resident 2 admitted to the facility in 2024 with diagnoses including end stage kidney disease and diabetes. A 5/24/24 Summary of Care Document for Resident 2 included discharge orders for a diabetic diet. On 5/29/24 at 2:53 PM Staff 4 (Dietary Manager) stated residents who required diabetic diets were individually interviewed to determine what level of diet compliance each resident wanted and Resident 2's preferences were added to her/his meal ticket to reflect her/his requests. Staff 4 acknowledged there were no prescribed recipes used or portion control guideline for staff preparing meals to follow for therapeutic diets including residents who required a diabetic diet. On 5/29/24 at 3:50 PM Staff 13 (RD) acknowledged the facility approved therapeutic diets, which included a diabetic diet, should be printed and followed. 34703 2. Resident 23 admitted to the facility in 2024 with a diagnosis of malnutrition. A 2/2/24 Admission MDS indicated Resident 23 was cognitively intact. An 4/23/24 physician order indicated Resident 23 was to have nutritionally enhanced meals. A review of Resident Council minutes dated 4/22/24 revealed residents were not receiving what they ordered at mealtimes. On 5/29/24 at 9:13 AM Resident 23 was observed sitting in her/his bedroom with a plate of one small pancake and a small sausage patty, and there were no beverages. Resident 23 stated she/he always ordered oatmeal for breakfast but never received it. On 5/29/24 at 12:30 PM Staff 4 (Dietary Manager) stated if a resident did not complete a meal order the facility prepared whatever was on the menu. Staff 4 acknowledged he was aware Resident 28 always wanted fruit but sometimes it was not provided. 3. Resident 28 admitted to the facility in 2023 with diagnoses including diabetes. A 5/10/24 Significant Change MDS indicated the resident was cognitively intact. A physician order dated 10/12/23 revealed Resident 28 was to receive a CCHO (low carbohydrate) diet related to her/his diagnosis of diabetes. (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	05/31/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/28/24 at 10:42 AM Resident 28 stated she/he was a diabetic and was not to receive extra carbohydrates. Resident 28 stated she/he marked out carbohydrates on her/his meal order but still received the carbohydrates, and did not receive the fruit she/he ordered. On 5/29/24 at 12:30 PM Staff 4 (Dietary Manager) stated if a resident did not complete a meal order the facility prepared whatever was on the menu. Staff 4 acknowledged he was aware Resident 28 always wanted fruit but sometimes it was not provided.

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	05/31/2024

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 34703 Based on observation, interview and record review it was determined the facility failed to ensure meals were palatable, attractive, and at an appetizing temperature for 1 of 1 kitchen and 3 of 4 sampled residents (#s 9, 11 and 23) reviewed for food quality. This placed residents at risk for unmet nutritional needs. Findings include: 1. Resident 9 admitted to the facility in 2023 with diagnoses including cancer. An 10/10/23 Significant Change MDS indicated the resident was cognitively intact. On 5/28/24 at 11:23 AM Resident 9 stated the food was always cold and the meat was chewy. On 5/30/24 at 12:35 PM a test tray was delivered to surveyors. The plate warmer was cool to touch, the meat was hard, and the rice was lukewarm. On 5/30/24 at 12:37 PM Staff 2 (DNS) and Staff 3 (Regional RN) acknowledged the food was not hot and the meat was hard. 2. Resident 23 admitted to the facility in 2024 with a diagnosis of malnutrition. A 2/2/24 Admission MDS indicated Resident 23 was cognitively intact. On 5/29/24 at 1:03 PM Resident 23's lunch had raw hamburger in the taco casserole. On 5/29/24 at 1:05 PM Staff 4 (Dietary Manager) verified the hamburger was raw. On 5/30/24 at 12:35 PM a test tray was delivered to surveyors. The plate warmer was cool to touch, the meat was hard, and the rice was lukewarm. On 5/30/24 at 12:37 PM Staff 2 (DNS) and Staff 3 (Regional RN) acknowledged the food was not hot and the meat was hard. 26991 3. Resident 11 admitted to the facility in 2023 with a diagnosis of surgical infection. An 4/6/24 quarterly MDS revealed Resident 11 was able to answer questions but had moderate cognitive impairment. On 5/28/24 at 10:07 AM Resident 11 stated she/he ate in her/his room and the food was cold by the time it arrived. On 5/30/24 at 12:35 PM a test tray was delivered to surveyors. The plate warmer was cool to touch, and the rice was lukewarm. (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	05/31/2024

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/24 at 12:37 PM Staff 2 (DNS) acknowledged the food was not hot.

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	05/31/2024

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 47001 Based on observation, interview and record review it was determined the facility failed to honor resident food preferences for 2 of 4 (#s 22 and 28) sampled residents reviewed for food. This placed residents at risk for unmet needs. Findings include: 1. Resident 22 admitted to the facility in 4/2023 with diagnoses including diabetes. An 4/27/24 MDS revealed Resident 22 was cognitively intact. On 5/28/24 at 9:49 AM Resident 22 stated she/he frequently did not get what was requested when her/his meal was delivered. Resident 22 stated for breakfast she/he received scrambled eggs, an English muffin and cold cereal with no milk. Resident 22 requested milk for her/his cereal but was informed there was no milk available. On 5/29/24 at 12:03 PM Resident 22 stated she/he requested scrambled eggs for breakfast, but instead received a pancake, fruit and raisin bran. On 5/29/24 at 12:53 PM Resident 22 stated she/he requested a ham and cheese sandwich, a salad and Jello for lunch, but instead she/he received chicken casserole. On 5/29/24 at 11:47 AM Staff 4 (Dietary Manager) stated if a resident did not complete a meal request he looked at the dietary profile to figure out what the resident wanted. 34703 2. Resident 28 admitted to the facility in 2023 with diagnoses including diabetes. A 5/10/24 Significant Change MDS indicated the resident was cognitively intact. A physician order dated 10/12/23 revealed Resident 28 was to receive a CCHO (low carbohydrate) diet related to her/his diagnosis of diabetes. On 5/28/24 at 10:42 AM Resident 28 stated she/he had a diabetic diet and was not to receive a lot of carbohydrates. Resident 28 stated she/he marked out carbohydrates on her/his meal order, but still received the carbohydrates On 5/29/24 at 2:53 PM Staff 4 (Dietary Manager) acknowledged there was no written documentation on portion sizes or what type of restrictions each resident should have with diets including CCHO (controlled carbohydrate), NEM (nutritionally enhanced meal) or NAS (no added salt).

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	05/31/2024

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 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. 34703 Based on observation, interview, and record review it was determined the facility failed to ensure beard restraints were worn during meal preparation for 1 of 1 sampled kitchen reviewed for sanitary food practices. This placed residents at risk for contaminated food. Findings include: A review of the facility's policy Dietary Dress Code dated 1/2024 revealed beards must be clean, well-groomed and must be completely covered with a beard covering. On 5/28/24 at 8:10 AM Staff 4 (Dietary Manager) and Staff 26 (Cook) were observed preparing food in the kitchen without beard restraints. Staff 4 indicated he was not aware staff had to wear beard coverings. On 5/29/24 at 12:01 PM Staff 13 (RD) acknowledged staff were to wear beard restraints while working in the kitchen.

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	05/31/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47001 Based on interview and record review it was determined the facility failed to provide immunizations to 1 of 5 sampled residents (#21) reviewed for immunizations. This placed residents at risk for infections. Findings include: Resident 21 was admitted to the facility in 8/2023 with diagnoses including chronic respiratory failure. A review of Resident 21's immunizations revealed she/he was not offered a Prevnar 20 vaccine, but was eligible to receive the Prevnar 20 vaccine. On 5/30/24 at 2:44 PM Staff 2 (DNS) acknowledged Resident 21 was eligible for a Prevnar 20 vaccine and it was not offered to her/him.