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	09/19/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review it was determined the facility failed to maintain safe water temperatures for 1 of 2 halls ([NAME] Falls Hall). This placed residents at risk for burns. Findings include:An undated Water Temperature Instructions sheet for logging facility water audits revealed: Test the water at various locations thought the facility. For burn prevention the domestic water temperatures were to be kept below 120 degrees Fahrenheit. 1.Resident 9 was admitted to the facility in 7/2025 with a diagnosis of anxiety. Resident 9's 6/22/25 Quarterly MDS revealed she/he was cognitively intact.On 9/16/25 at 2:42 PM with Staff 38 (Maintenance Director) Resident 9's sink water was observed to be 123.3 degrees F. Staff 38 stated he checked the water weekly but usually did the audits in the morning, and the water temperatures were never that high. On 9/17/25 at 7:48 AM Resident 9 stated she/he lovedthe hot water.On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and temperatures should be below 120 degrees F. 2. Resident 16 was admitted to the facility in 9/2022 with a diagnosis of diabetes. Resident 16's 7/1/25 Quarterly MDS Revealed she/he was cognitively intact.On 9/16/25 at 2:42 PM with Staff 38 (Maintenance Director) Resident 9's sink water was observed to be 123.3 degrees F. Staff 38 stated he checked the water weekly but usually did the audits in the morning, and the water temperatures were never that high. On 9/17/25 at 7:48 AM Resident 16 stated she/he loved the hot water.On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and temperatures should be below 120 degrees F. 3. Resident 19 was admitted to the facility in 8/2025 with a diagnosis of a stroke. Resident 19's 8/5/25 admission MDS revealed she/he was cognitively intact.On 9/16/25 at 2:29 PM with Staff 38 (Maintenance Director) Resident 19's sink water was observed to be 132.1 degrees F. Staff 38 stated he checked the water weekly but usually did the audits in the morning, and the water temperatures were never that high. On 9/17/25 at 8:03 AM Resident 19 stated she liked the water hot.On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and the temperatures should be below 120 degrees F. 4. Resident 26 was admitted to the facility in 7/2025 with a diagnosis of a stroke. On 9/16/25 at 2:35 PM with Staff 38 (Maintenance Director) Resident 2's sink water was observed to be 124.7 degrees F. Staff 38 stated he checked the water temperatures weekly but usually did the audits in the morning, and the water temperatures were never that high. On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and the temperatures should be below 120 degrees F. On 9/16/25 at 3:33 PM Staff 28 (LPN) stated residents did not report hot water concerns and usually staff had to let the water run for a while for the water to become warm enough for residents to shower. On 9/16/25 at 3:35 PM Staff 21 (CNA) stated residents usually reported the water was not warm enough. On 9/17/25 Resident 26 was not available for an interview. 5. Resident (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	32 was admitted to the facility in 10/2024 with a diagnosis of heart disease. Resident 32's 8/5/25 Quarterly MDS revealed she/he wascognitively impaired.On 9/16/25 at 2:35 PM with Staff 38 (Maintenance Director) Resident 32's sink water was observed to be 124.7 degrees F. Staff 38 stated he checked the water temperatures weekly but usually did the audits in the morning, and the water temperatures were never that high.On 9/16/25 at 3:33 PM Staff 28 (LPN) stated residents did not report hot water concerns and usually staff have to let the water run for a while for the water to become warm enough for residents to shower. On 9/16/25 at 3:35 PM Staff 21 (CNA) stated residents usually reported the water was not warm enough. On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and the temperatures should be below 120 degrees F. 6. Resident 33 was admitted to the facility in 8/2024 with a diagnosis of liver disease. Resident 33's 8/11/25 Annual MDS revealed she/he was cognitively intact.On 9/16/25 at 2:29 PM with Staff 38 (Maintenance Director) Resident 33's sink water was observed to be 132.1 degrees F. Staff 38 stated he checked the water weekly but usually did the audits in the morning, and the water temperatures were never that high. On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and the temperatures should be below 120 degrees F.On 9/17/25 at 8:57 AM Resident 33 stated the staff assisted her/him with the water, and she/he did not have any concerns with the temperatures. 7. Resident 52 was admitted to the facility in 9/2025 with a diagnosis of respiratory failure. Resident 52's 9/16/25 admission MDS Revealed she/he was moderately cognitively impaired.On 9/16/25 at 2:35 PM with Staff 38 (Maintenance Director) Resident 52's sink water was observed to be 124.7 degrees F. Staff 38 stated he checked the water weekly but usually did the audits in the morning, and the water temperatures were never that high. On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and the temperatures should be below 120 degrees F. 8. Resident 54 was admitted to the facility in 9/2025 with a diagnosis of heart failure. Resident 54's 9/13/25 admission MDS revealed she/he was cognitively intact. On 9/16/25 at 2:34 PM with Staff 38 (Maintenance Director) Resident 54's sink water was observed to be 129.4 degrees F. Staff 38 stated he checked the water weekly but usually did the audits in the morning, and the water temperatures were never this high. On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day.On 9/16/25 at 3:33 PM Staff 28 (LPN) stated residents did not report hot water concerns and usually staff have to let the water run for a while for the water to become warm enough for residents to shower. On 9/16/25 at 3:35 PM Staff 21 (CNA) stated residents usually reported the water was not warm enough. Resident 54 was not available to be interviewed.On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day. 9. Resident 55 was admitted to the facility in 9/2025 with a diagnosis of heart disease.Resident 55's 9/14/25's admission MDS revealed she/he was cognitively intact.On 9/16/25 at 2:29 PM with Staff 38 (Maintenance Director) Resident 55's sink water was observed to be 132.1 degrees F. Staff 38 stated he checked the water weekly but usually did the audits in the morning, and the water temperatures were never that high. On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and the temperatures should be below 120 degrees F. On 9/17/25 at 8:59 AM Resident 55 stated she/he did not think the water was too hot and the temperature wasjust fine. 10. Resident 58 was admitted to the facility in 9/2025 with a diagnosis of a hip fracture.Resident 58's 9/10/25 admission Profile indicated she/he had some short-term memory issues but was ableto communicate without difficulty.On 9/16/25 at 2:29 PM with Staff 38 (Maintenance Director) Resident 58's sink water was observed to be 132.1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	degrees F. Staff 38 stated he checked the water weekly but usually did the audits in the morning, and the water temperatures were never that high. On 9/17/25 at 8:55 AM Resident 58 stated she/he did not have concerns with the water being too hot.On 9/16/25 at 3:36 PM Staff 1 (Administrator) stated the water audits should not be done at the same time each week to ensure the water temperature variances were identified throughout the day and the temperatures should be below 120 degrees F.

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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. Based on observation and interview the facility failed to ensure proper hand hygiene and sanitary surfaces for 1 of 1 kitchen. This placed residents at risk for cross-contamination. Findings include:On 9/15/25 at 11:29 AM, Staff 19 (Dietary Manager) picked up and sorted meal tickets with gloved hands and then picked up bread without washing his hands and changing gloves. On 9/15/25 at 11:30 AM, Staff 19 opened the walk-in cooler with gloved hands and then handled raw foods without washing his hands and donning clean gloves.On 9/15/25 at 11:31 AM, Staff 20 opened the walk-in cooler and removed condiments with his bare hands and then touched clean dishes without washing his hands and donning gloves.On 9/17/25 at 11:12 AM, Staff 19 picked up a clipboard with gloved hands then picked up cooked meat without washing his hands and donning clean gloves. On 9/17/25 at 11:28 AM, Staff 19 stated CNAs help residents complete meal tickets each morning. Staff 19 stated the tickets were a contaminated surface. On 9/17/25 at 11:31 AM, Staff 19 took a meal ticket with gloved hands and placed it on a cutting board and after plating the food, placed the ticket on the tray and picked up the next ticket, placing it on the cutting board. On 9/17/25 at 11:49 AM, Staff 19 sorted meal tickets with gloved hands then placed a quesadilla on the same cutting board, cut it, and placed it on a plate without washing his hands or changing gloves. On 9/17/25 at 12:59 PM, Staff 19 stated he was aware he should not touch items in the kitchen that are not sanitized with gloved hands without washing his hands and donning clean gloves. On 9/18/25 at 12:45 PM, Staff 19 stated the kitchen staff had not been using proper hand hygiene while preparing and plating resident meals. On 9/18/25 at 1:05 PM, Staff 20 stated he was aware the walk-in cooler handle and the meal tickets were contaminated surfaces, and he acknowledged touching both with gloved hands and not washing his hands or changing his gloves afterward. On 9/19/25 at 10:33 AM, Staff 1 (Administrator), Staff 15 (Regional VP) and Staff 11 (Regional Director of Clinical Operations) acknowledged the facility failed to practice proper hand hygiene.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determined the facility failed to follow infection control standards for 2 of 2 sampled residents (#s 1 and 24) reviewed for hospice and transmission-based precautions. This placed residents at risk for exposure to, and contraction of, infectious diseases. Findings include:1. Resident 24 was admitted to the facility in 8/2025 with a diagnosis of cellulitis (infection of the skin). Resident 24's Care Plan initiated 8/29/25 revealed she/he was used a walker with transfers and was to be supervised. Resident 24 had a history of a drug-resistant organism in her/his urine, was at times incontinent, and had cellulitis to her/his leg requiring precautions during high contact activities. On 9/17/25 at 9:20 AM a Contact Isolation sign was observed outside of Resident 24's door. The sign directed staff to put on a gown and gloves prior to entering the resident's room. Staff 36 was observed to enter Resident 24's room after putting on a disposable gown and gloves. Resident 24 exited the room and Staff 36 followed her/him after she removed her gloves and performed hand hygiene. Staff 36 did not remove her disposable gown. Staff 36 stated she did not remove the gown because she did not want Resident 24 to walk down the hall without assistance. On 9/18/25 at 12:21 PM Staff 14 (IP) stated staff should have removed the gown prior to exiting the room. 2. Resident 1 was admitted to the facility in 6/2025 with diagnoses including chronic kidney disease, and disorders of the bladder. The facility's Transmission-Based Precautions Policy and Procedure revised 11/2024, indicated the following: Enhanced Barrier Precautions (EBP) were implemented alongside standard precautions to reduce transmission of multidrug-resistant organisms (germs that resist treatment with multiple antibiotics). EBP required targeted use of glove and gowns during high-contact resident care activities such as transferring and device care, including urinary catheter use. PPE included gloves and gown prior to the high-contact care. Face protection (mask, goggles, or face shield) may also be needed if there was risk for splash or spray. a. A 6/25/25 care plan indicated Resident 1 was at risk for infection due to a history of aspiration (inhaling food or fluid into the lungs), pneumonia, indwelling catheter (tube placed in the bladder to drain urine), and a history of multiple UTIs. Interventions included to implement EBP during high-contact care activities such as transferring, and urinary catheter care. On 9/17/25 at 9:17 AM, Staff 13 (CNA) and Staff 12 (CNA) were observed assisting Resident 1 with a transfer using a mechanical lift. Both staff wore gloves; no other PPE was observed. On 9/17/25 at 9:26 AM, Staff 13 and Staff 12 stated they understood EBP applied to changing briefs or emptying a catheter, and they would wear full PPE during those tasks. They did not believe gowns were required for transferring Resident 1 with a mechanical lift. On 9/17/25 at 9:27 AM, the EBP sign posted next to Resident 1's room indicated all health care personnel must wear gloves and gown for high contact resident care activities including bathing, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferring, changing linens, assisting with toileting and providing hygiene. On 9/19/25 at 7:14 AM, Staff 11 (Regional Director of Clinical Operations) stated staff were expected to follow the EBP sign and policy for using the proper PPE while caring for a resident. b. On 9/18/25 at 2:01 PM, Staff 18 (Hospice RN) was overheard informing Resident 1 her/his catheter was leaking, and she was going to turn on the light to change the catheter. Staff 18 was observed wearing gloves but no gown. At 2:19 PM, Staff 18 removed her gloves; no gown was observed. Staff 18 confirmed she changed Resident 1's catheter and wore only gloves. She acknowledged a gown should be worn during catheter care. On 9/19/25 at 7:14 AM Staff 11 (Regional Director of Clinical Operations) stated staff were expected to follow the EBP sign and policy for using the proper PPE while caring for residents.

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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. Based on observation, interview and record review it was determined the facility failed to inform residents of the risks and benefits of psychotropic medication use for 2 of 5 sampled residents (#6 and 36) reviewed for medications and dementia. This placed residents at risk for being uniformed. Findings include: Resident 6 was admitted to the facility in 1/2025 with diagnoses including depression and bipolar disorder. A Physician's order revealed Resident 6 received Depakote (a mood stabilizer) daily. Review of the clinical record revealed no evidence the risks and benefits of Depakote were discussed with her/him. On 9/18/25 at 8:47 AM, Staff 11 (Regional Director of Clinical Operations) and Staff 14 (Assistant Director of Nursing Services) verified the risks and benefits were not reviewed with Resident 6. 2. Resident 36 was admitted to the facility in 8/2022 with diagnoses including dementia. Resident 36 had a responsible party who made her/his medical decisions. A review of the resident's clinical record on 9/16/25 revealed an order for Depakote Sprinkles (a medication used to impact agitation and mood) on 8/21/25. A review of the resident's MAR revealed the first dose of Depakote Sprinkles was administered on 8/22/25. No record of informed consent by the resident representative was found during the initial record review completed 9/16/25. Further review of the clinical record on 9/18/25 revealed a Psychotropic Medication Consent dated 9/18/25. On 9/18/25 at 3:21 PM, Staff 26 (RN) stated she did not know she needed to obtain informed consent from the resident representative before administering Depakote Sprinkles. On 9/18/25 at 3:34 PM, Staff 14 (RN/Assistant DNS) stated staff were required to obtain informed consent from the resident or resident representative prior to administering a psychotropic medication.

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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. Based on interview and record review it was determined the facility failed to protect the residents' right to be free from neglect and protect the residents' rights to be free from verbal and physical abuse by Staff 24 for 2 of 4 sampled residents (#s 47 and 51) reviewed for neglect and abuse. This placed residents at risk for abuse and neglect. Findings include: Resident 47 was admitted to the facility in 4/2024 with diagnoses including quadriplegia, Amyotrophic Lateral Sclerosis (ALS, a progressive disease which affects physical function). A care plan dated 4/23/24 directed staff to encourage Resident 47 to reposition frequently for pressure relief. The Documentation Survey Report 10/1/24 indicated Resident 47 was not repositioned on the night shift. The Alleged Neglect investigation dated 10/2/24 revealed Staff 2 (DNS) was notified Resident 47 did not receive care during the night shift on 10/1/24. Resident 47 stated Staff 5 (Former CNA) was useless, entered the room, turned off the call light, and did not provide care. Resident 47 also reported she/he was not offered any hydration or toileting. Due to ALS, Resident 47 was unable to eat or hydrate independently. On 9/16/25 at 8:14 AM, Staff 5 stated Resident 47 did receive care the night of 10/1/25. On 9/16/25 at 8:25 AM, Staff 8 (CNA) stated Resident 47 was very upset on the morning of 10/2/24. Staff 5 reported she could not assist Resident 47 due to back issues. On 9/16/25 at 11:07 AM, Staff 6 (Former Nurse's Aide Student) stated she saw Staff 5 enter Resident 47's room and turn off the call light. Staff 5 then told Staff 6 not to enter the room, saying she would take care of it. Staff 6 reported the concern to Staff 2 on the morning of 10/2/24. On 9/16/25 at 11:12 AM, Staff 7 (CNA) stated she did not go into Resident 47's room because Staff 5 was assigned to her/his room. On 9/16/25 at 11:43 AM, Staff 9 stated she came in the morning of 10/2/24 and Resident 47 complained about night shift from 10/1/24 not taking care of her/him. Staff 6 told her Staff 5 kept turning off Resident 47's call light. On 9/19/25 at 7:17 AM, Staff 1 (Administrator) stated staff were expected to provide care and services and not neglect residents. 2: Resident 51 was admitted to the facility in 8/2023 with diagnoses including infection. On 9/18/25 at 8:30 AM, Staff 21 (CNA) stated she was assisting Staff 24 (CNA) to provide care for Resident 51 on 4/27/25. Staff 21 stated Staff 24 was rough with the resident while placing a chuck (a device used to help reposition a resident) under the resident. She stated Staff 24 told Resident 51 she/he was not exactly easy to move when Resident 51 objected to the rough treatment by Staff 24. Staff 21 stated Staff 24 then jerked the chuck under the resident to reposition him without counting (a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	method used to be sure staff reposition the resident in unison) and the resident told Staff 24 he was hurting him. Staff 21 stated Staff 24 ignored the resident and left the room after repositioning her/him without providing the resident additional care. On 9/19/25 at 10:27 AM, Staff 16 (Social Services Director) stated Resident 51 informed her on 4/28/25 that Staff 24 had been abusive to her/him while providing care. A review of the investigation 5/1/25 by Staff 3 (former Administrator) and Staff 2 (DNS) revealed the facility could not rule out abuse to Resident 51 by Staff 24. Resident 51 was not available for interview. An attempt to interview Staff 24 on 9/16/25 was not successful. Staff 2 was not available for interview. Attempts to interview Staff 3 on 9/18/25 were not successful. On 9/19/25 at 10:33 AM, Staff 1 (Administrator), Staff 15 (Regional VP) and Staff 11 (Regional Director of Clinical Operations) acknowledged Resident 51 was abused by Staff 24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 allegations of neglect and abuse timely for 3 of 4 sampled residents (#s 21, 47, and 51) reviewed for abuse and neglect. This placed residents at risk for neglect and abuse. Findings include:1. Resident 21 was admitted to the facility 8/25/25 with diagnoses including pelvic fracture. On 9/15/25 at 3:52 PM, Resident 21 stated she/he reported an allegation of abuse by Staff 33 (RN) and Staff 34 (CNA) that occurred on 9/7/25. The resident alleged an RN, and a CNA gave her/him a suppository against her/his will. Resident 21 also alleged Staff 34 forcefully placed her hand on the resident's hip to hold her/him down. Resident 21 stated she/he spoke to Staff 2 (DNS) and Staff 1 (Administrator) about the incident and wanted to file a grievance. The facility reported the alleged abuse to the State Agency on 9/16/25. On 9/16/25 at 7:53 AM, Staff 2 stated she and Staff 1 spoke with the resident and the staff involved when they learned of the incident 9/8/25. Staff 2 stated she did not take further action. On 9/19/25 at 10:33 AM, Staff 1 (Administrator), Staff 15 (Regional VP) and Staff 11 (Regional Director of Operations) stated allegations of abuse should be reported to the state agency within 2 hours. 2: Resident 51 was admitted to the facility in 8/2023 with diagnoses including infection. On 4/28/25 Resident 51 reported she/he had been verbally and physically abused by Staff 24 (CNA). Staff 2 (DNS) and Staff 3 (former Administrator) learned of the alleged abuse on 4/28/25 at 12:15 PM and a FRI was submitted to the State Agency on 4/28/25 at 3:49 PM. Resident 51 was not available for interview. Staff 2 was not available for interview. An attempt to interview Staff 24 on 9/16/25 was not successful. Attempts to interview Staff 3 on 9/18/25 were not successful. On 9/18/25 at 8:30 AM, Staff 21 (CNA) stated she was assisting Staff 24 to provide care for Resident 51 on 4/27/25. Staff 21 stated Staff 24 handled the resident roughly while placing a chuck (a device used to help reposition a resident) under the resident. She stated Staff 24 told Resident 51 she/he was not exactly easy to move when Resident 51 objected to the rough handling by Staff 24. Staff 21 stated Staff 24 then jerked the chuck under the resident to reposition her/him without counting (a method used to be sure staff reposition the resident in unison). The resident told Staff 24 he was hurting her/him. Staff 21 stated Staff 24 ignored the resident and left the room after repositioning her/him without providing additional care. On 9/19/25 at 10:27 AM, Staff 16 (Social Services Director) stated Resident 51 informed her on 4/28/25 Staff 24 had been abusive to her/him while providing care. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/25 at 10:33 AM, Staff 1 (Administrator), Staff 15 (Regional VP) and Staff 11 (Regional Director of Operations) stated allegations of abuse should be reported to the state agency within 2 hours and stated facility records showed the alleged abuse was not reported timely. 3. Resident 47 was admitted to the facility in 4/2024 with diagnoses including quadriplegia, Amyotrophic Lateral Sclerosis (ALS, a progressive disease which affects physical function). A facility reported incident dated 10/3/24 at 10:00 AM indicated on 10/2/24 at 12:00 PM, Staff 4 (CNA) reported Staff 5 did not provide care to Resident 47 during the night shift on 10/1/24. Attempts to interview Staff 4 on 9/16/25 and 9/18/25 were unsuccessful. On 9/16/25 at 11:07 AM, Staff 6 (Former Nurse's Aide Student) stated she observed Staff 5 enter Resident 47's room and turn off the call light during night shift on 10/1/24 without providing care or services. Staff 6 reported the concern to Staff 2 between 6:00 AM and 7:00 AM on 10/2/24. Staff 2 was not available for interview. On 9/19/25 at 7:19 AM, Staff 1 (Administrator) stated she would expect staff to report an allegation of neglect to the State agency within 24 hours if no major injury occurred.

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	09/19/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide residents with a written bed hold notification, including reserved bed hold payment, at the time of transfer to the hospital and notify the Ombudsman for 1 of 2 sampled residents (# 6) reviewed for hospitalization and discharge. This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include:Resident 6 was admitted to the facility in 1/2025 with diagnoses including kidney failure.A review of Resident 6's clinical record revealed she/he was transferred to the hospital on [DATE]. No evidence was found in the clinical record to indicate a written notice of the facility's bed hold policy was provided to the resident or her/his representative. No documentation was found indicating the Ombudsman was notified of the transfer.On 9/18/25 at 8:47 AM, Staff 11 (Regional Director of Clinical Operations) and Staff 14 (Assistant Director of Nursing Services) verified a written bed hold notification was not provided to Resident 6 or her/his representative at the time of transfer to the hospital, and the Ombudsman was not notified of the transfer.

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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. Based on interview and record review it was determined the facility failed to follow physician orders and failed to monitor a resident for a change of condition for 3 of 5 sampled residents (#s 2, 5, and 8) reviewed for medications. This placed residents at risk for unmet care needs. Findings include:1. Resident 2 was admitted to the facility in 9/2022 with a diagnosis of heart disease. Per Mayo Clinic: Hypokalemia (low potassium) symptoms of irregular heart rhythms were the most worrisome complication of very low potassium levels, particularly in people who have heart disease Resident 2's 8/11/25 Basic Metabolic Panel results revealed her/his potassium level was 2.7 (normal range 3.4-4.9). Resident 2's Progress Notes revealed:-On 8/11/25 Resident 2 was seen by her/his physician at the medical clinic and laboratory samples were obtained. -On 8/12/25 her/his physician called the facility with orders to transport Resident 2 to the local emergency department due to a critically low potassium level. The note indicated Resident 2 refused to be transported to the hospital due to the cost of the transportation. -On 8/13/25 at 8:42 AM Resident 2 was transported to the hospital for a critically low potassium level.-On 8/13/25 at 5:03 PM Resident 2 was admitted to the hospital with a diagnosis of NSTEMI (Non-ST-elevation Myocardial Infarction/type of heart attack where a partial blockage of the artery reduces blood flow to the heart causing muscle damage). Resident 2's clinical record revealed no documentation Resident 2's physician was informed the resident was not sent to the emergency department per physician orders on 8/12/25 and there was no documented monitoring of the resident after she/he refused to go to the hospital. On 9/17/25 at 3:49 PM Staff 31 (LPN) stated Resident 2's physician called the facility and provided orders to send Resident 2 to the emergency room due to a critically low potassium level. When the emergency medical technicians arrived, they informed Resident 2 the cost of the transport would likely not be covered with insurance, and she/he would need to pay for transportation. Resident 2 did not want to pay for transportation. Staff 31 stated she did not call the physician to inform him the orders were not implemented. On 9/17/25 at 3:06 PM Staff 32 (LPN Patient Care Coordinator) stated there was no indication the staff communicated with Resident 2's physician that orders to send Resident 2 to the emergency room were not followed and verified there was no monitoring of Resident 32 until she/he was transported to the hospital the following day, despite being at risk for complications related to low potassium levels. 2. Resident 5 was admitted to the facility in 9/2024 with a diagnosis of kidney disease. Resident 5's 9/2/25 Order Summary Report revealed she/he had dialysis on Mondays, Wednesdays, and Fridays from 6:00 AM to 9:00 AM. Orders also included Resident 5 was to be administered Aspirin (non-steroidal anti-inflammatory) daily, calcium acetate (binds with phosphate in food) with meals daily, midodrine (treats low blood pressure) every Monday, Wednesday, and Friday, Allopurinol (treats gout) daily, omeprazole (treats acid reflux) daily, and a multivitamin (supplement) daily.Resident 5's 8/2025 and 9/2025 MAR revealed she/he did not receive Allopurinol on 8/6/25, 8/11/25, 8/15/25, 9/3/25, and 9/15/25, midodrine on 8/6/25, 8/11/25, 8/27/25, 9/3/25, and 9/15/25, multivitamin on 8/6/25, 8/11/25, 8/27/25, 9/3/25, and 9/15/25, omeprazole on 8/6/25, 8/27/25, 9/1/25, 9/3/25, calcium acetate 8/6/25 AM dose, 8/22/25 AM dose, 8/27/25 AM dose, 8/29/25 AM dose, 9/3/25 AM dose, 9/10/25 AM dose, 9/12/25 AM dose, and 9/15/25 AM dose, and Aspirin on 8/6/25, 8/11/25, 8/27/25, 9/3/25, and 9/15/25. On 9/18/25 at 3:06 PM Staff 14 (Assistant DNS) stated Resident 5 had dialysis early mornings on Monday, Wednesday, and Friday, and staff often did not provide the medications as ordered on dialysis days. 3. Resident 8 was admitted to the facility in 2/2024 with a diagnosis of dementia. Resident 8's 9/2/25 Order Summary Report revealed she/he was to be administered Bisacodyl (laxative) tablets PRN if she/he did not have a bowel movement for two days. Resident 8's bowel record from 8/20/25 through 9/18/25 revealed she/he did not have a bowel movement for two days from 8/20/25 through 8/23/25, 9/5/25 through 9/7/25, and 9/15/25 though 9/17/25. Resident 8's 8/2025 and 9/2025 MAR revealed she/he was not administered Bisacodyl after not having a bowel movement for two days on 8/22/25, 9/1/25, 9/7/25, and 9/17/25. On 9/18/25 at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:44 AM Staff 35 (RN) stated the night shift staff ran a bowel report for all residents. If a resident did not have a bowel movement for three days bowel care was initiated. On 9/18/25 at 3:06 PM Staff 14 (Assistant DNS) stated the facility's bowel protocol was to provide bowel care after a resident did not have a bowel movement for three days. Staff 14 verified staff did not follow Resident 8's physician orders for bowel care which were to be administered if she/he did not have a bowel movement for two days.