STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385172	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dalles Health & Rehabilitation Center	1023 W. 25th Street The Dalles, OR 97058

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 42222 Based on interview and record review it was determined the facility failed to treat residents with dignity and respect for 1 of 3 sampled residents (#2) reviewed for dignity. This placed residents at risk for a decrease in quality of life. Findings include: On 2/21/24, the Past Noncompliance was corrected when the facility identified the incident and determined Resident 2 was not treated with dignity and respect. The facility's Plan of Correction included: -Removed Staff 7 from her duties; -Audited the hall Staff 7 was assigned to; -Provided in-service training to all nursing staff for abuse and the reporting of abuse; and -Provided signature sheets verifying nursing staff had completed the training. Resident 2 admitted to the facility in 2022, with diagnoses including infection and inflammation. Resident 2's care plan dated 1/18/24, indicated she/he had moderate cognitive impairment but was able to make her/his needs and preferences known. On 2/21/24 the facility submitted a report to the state agency which indicated on 2/20/24, Staff 7 (Former CNA) yelled at Resident 2 and tried to get her/him out of her/his recliner to go to bed. When Resident 2 refused, Staff 7 threw something which hit the resident's hand. The facility initiated an investigation, determined Staff 7 verbally abused Resident 2 and terminated her employment. On 5/15/24 at 12:00 PM, Resident 2 was observed eating lunch in the dining room and later that day sleeping in her/his room. On 5/15/24 at 12:02 PM, Witness 1 (Spouse) stated she/he visited Resident 2 at the facility daily. Witness 1 saw Resident 2 the day after the incident occurred and stated she/he was not fearful or depressed about the incident but angry at Staff 7 for waking her/him up. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER: The Dalles Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1023 W. 25th Street The Dalles, OR 97058	

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 1:44 PM, Staff 6 (CNA) stated she was the NOC shift CNA assigned to Resident 2 on 2/20/24. Staff 6 stated the previous shift's CNA told her Resident 2 wanted to sleep in her/his recliner that night and reported she/he had been sleeping well in the chair. Staff 6 stated Staff 7 asked her why Resident 2 was in her/his chair. Staff 6 told Staff 7, Resident 2 wanted to sleep in her/his chair as this was the best sleep the resident has had in a long time. Staff 6 stated she told Staff 7 she would take care of the resident, however, Staff 7 went to Resident 2's room. Staff 6 observed Resident 2's call light was on and went to the resident's room. Staff 6 observed Staff 7 flinging the sit to stand lift out of the resident's room and heard Resident 2 state I don't understand what's happening. I want to be left alone. Staff 6 stated she heard Staff 7 state the resident doesn't want to fucking go to bed and she/he is being a jerk and if the resident didn't go to bed and her/his butt hurt later, it would be the resident's fault. Staff 6 stated her and Staff 7 left Resident 2's room at the resident's request. Staff 6 stated she returned a few minutes later and the resident stated she/he didn't know why she/he was treated that way by Staff 7 and she/he just wanted to be left alone. Resident 2 told Staff 6 she/he was fine but Staff 7 had taken off her/his blankets, told her/him to go to bed and threw the blankets back on the resident when she/he refused. Staff 6 stated she observed the resident's blankets piled up around her/him and helped the resident straighten them out. Staff 6 stated the next day Resident 2 was fine and had no other issues as a result of the incident. On 5/17/24 at 11:50 AM, Staff 7 stated she had not yelled at Resident 2 but had to raise her voice because the resident was hard of hearing. Staff 7 stated she was not assigned to Resident 2's hall on 2/20/24, but the person assigned is lazy and wouldn't do it so I went to check on her/him. Staff 7 stated Resident 2 yelled at her when she went to her/his room and told her to get the f-out of her/his room. Staff 7 told Resident 2 that was fine and tried to put the call light on her/his blanket but the resident kept yelling at her, so she placed the call light on the bedside table and left the room. Staff 7 denied she threw the blankets or that she used profanity with the resident and stated she wanted to help her/him because she/he had sat in the recliner for over eight hours. On 5/17/24 at 12:41 PM, Staff 1 (Administrator) stated he interviewed Resident 2 the next day and the resident stated she/he didn't want Staff 7 to provide care to her/him any longer. Resident 2 stated she/he had not been sleeping well in her/his bed and wanted to sleep in the recliner, which nursing staff said was fine. Staff 1 stated Resident 2 reported to him that Staff 7 went to her/his room, woke her/him up, put the overhead light on, removed the blankets off her/him and told her/him to go to bed. Staff 1 stated Resident 2 further reported she/he asked Staff 7 to leave her/his room, which Staff 7 then threw her/his blankets back on to the resident and told the resident if her/his butt was sore not to blame her. Staff 1 stated Staff 7 was immediately placed on administrative leave, was interviewed and she stated Resident 2 was rude to her and noncompliant with getting into bed. Staff 1 confirmed he terminated Staff 7's employment when the investigation was completed and it was an expectation residents were treated with dignity and respect.