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Form Approved OMB
No. 0938-0391

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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dalles Health and Rehabilitation	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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, it was determined the facility failed to ensure a resident was free from sustaining a burn from a baseboard heater for 1 of 3 (#2) sampled residents revied for accidents. As a result, Resident 2 sustained second degree burns on her/his left foot and toes. Findings include:Resident 2 was admitted to the facility in 2025 with diagnosis including stroke and diabetic neuropathy (a condition that causes numbness to the hands and feet). Resident 2's 5/21/25 Care Plan indicated Resident 2 with impaired cognitive disturbance and safety awareness which included sliding out of bed at night and fidgeting with items on walls including keypads, fire alarms and picture frames.Resident 2's MDS identified the resident with a BIMS score of 13 out 15 indicating mild cognitive impairment. A 12/13/25 Facility Risk Management Report identified Resident 2 to have sustained a second degree burn on her/his left foot and toes after rolling out of bed and placing her/his foot on the residents' baseboard heater in the middle of the night. Staff 5 (CNA) was noted to have discovered Resident 2 lying on the floor whimpering with their left foot on the resident's baseboard heater. Per Staff 5's report, she removed Resident 2's foot from the heater and reported the occurrence to the charge nurse. Staff 5 confirmed the resident's bed was too close to the baseboard heater and due to the resident's diabetic neuropathy, she/he did not feel her/his foot begin to burn when Resident 2 placed her/his foot on the baseboard heater. Resident 2 was assessed and treated for second degree burns on his/her left foot. A 12/13/25 Skin and Wound Assessment indicated Resident 2 was assessed and determined after the incident to have sustained a second degree burn with multiple small blisters approximately 0.2 centimeters in length and 0.2 centimeters in width. On 4/27/26 at 2:16 PM, Staff 5 (CNA) confirmed she discovered Resident 2 on the floor and removed Resident 2's foot from the heater. Staff 5 stated the foot injury sustained by Resident 2 was pretty bad and upon assessment of the nurse the Resident 2 was treated for burns caused by direct contact with the baseboard heater. On 4/27/26 at 3:14 PM, Staff 3 (RNCM) stated Resident 2 experienced second degree burns due to rolling out of bed and placing her/his foot on the heater. Staff 3 stated that due to resident's diabetic neuropathy would not have been aware of the injury being caused by the baseboard heater. On 4/27/26 at 4:50 PM, Staff 1 (Administrator) acknowledged the findings of Resident 2 sustaining second degree burns on the resident's left foot and toes from the resident's baseboard heater. On 12/19/25, the deficient practice was identified by the facility and was corrected. The facility completed a root cause analysis of the incident and determined Resident 2 sustained a second-degree burn. The Plan of Correction included:In-service training and education for all staff.Other residents with cognitive impairment or fall risk were examined and alterations to their rooms were made accordingly to prevent burns from baseboard heaters and ensure resident safety. Findings were brought though the QAPI committee monthly for 3 months or until resolved by the committee.Daily and monthly audits were immediately implemented to prevent and ensure resident safety was maintained regarding baseboard heaters.

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