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	12/20/2024

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 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. 36494 Based on interview and record review it was determined the facility failed to follow physician orders for 2 of 7 sampled residents (#s 9 and 12) reviewed for hospitalization s and medications. This placed residents at risk for adverse medication side effects and fluid overload. Findings include: 1. Resident 12 was admitted to the facility in 1/2024 with diagnoses including chronic heart failure and COPD (Chronic Obstructive Pulmonary Disease). A Physician Order dated 4/19/24 revealed the following: -Daily Weights were to be obtained every morning and staff were to contact the provider for the following weight gain related to heart failure. -Three pounds in 24 hours. -Five pounds in a week. -If weight falls less less then 195, notify the provider. A review of Resident 12's 11/2024 and 12/2024 TARs and Weights and Vitals Summary revealed multiple occasions when Resident 12's weight increased by more than three pounds in a 24 hour period. There was no evidence found in Resident 12's medical record the physician was notified of the three pound weight gain in 11/2024 and 12/2024. On 12/18/24 at 3:37 PM, Staff 5 (LPN) and on 12/19/24 at 9:18 AM, Staff 8 (LPN) stated they obtained daily weights due to the resident's heart failure and concerns with edema. Staff 8 stated staff were to notify the physician when Resident 12 had a three pound increase in a 24 hour period. Staff 8 acknowledged the physician was not notified of the weight variances for 11/2024 and 12/2024. On 12/19/24 at 12:56 PM, and 12/20/24 at 8:37 AM, Staff 2 (DNS) confirmed staff did not follow physician orders related to monitoring Resident 12's weight gain. Staff 2 stated she expected staff to notify the physician when Resident 12 had a three pound increase in a 24 hour period. 48830 (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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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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 9 was admitted to the facility in 5/2023 with diagnoses including heart failure and a history of Gastrointestinal (GI) hemorrhage (any type of bleeding in the digestive tract). The 5/1/24 Annual MDS indicated Resident 9 was severely cognitively impaired. A 11/8/24 Progress Note indicated Resident 9 was sent to the hospital and admitted for a GI bleed. A 11/10/24 Hospital Discharge Summary revealed a physician order to discontinue aspirin 81 mg, hold Eliquis 5 mg for one week and start Eliquis 2.5 mg BID on 11/15/24. It was noted the dosage was reduced due to a history of GI bleed. A review of the 11/2024 and 12/2024 MAR revealed Resident 9 received the following: -Eliquis 2.5 mg BID for three days, 11/10/24 through 11/13/24 AM. -Eliquis 5 mg BID from 11/13/24 PM through 12/19/24. -aspirin 81 mg from 11/10/24 through 12/19/24. On 12/20/24 at 8:21 AM Staff 2 (DNS) stated the 11/10/24 hospital discharge orders were inaccurately transcribed in Resident 9's medical record. Staff 2 acknowledged the physician orders were not followed; Resident 9 received the incorrect dosage of Eliquis from 11/13/24 through 12/19/24, and received aspirin after it was discontinued by the physician.

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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. 36494 Based on interview and record review it was determined the facility failed to ensure staff provided two-person assistance when transferring a resident for 1 of 4 sampled residents (#33) reviewed for accidents. This failure resulted in Resident 33 falling from a mechanical lift and sustaining a laceration to the forehead which required sutures. Findings include: Resident 33 admitted to the facility in 4/2022 with diagnoses including heart disease and memory loss. A care plan dated 1/21/24 revealed Resident 33 was dependent on staff for her/his ADL care needs and required two-person assistance with a mechanical lift for transfers. A Fall Investigation initiated on 8/2/24 and completed on 8/5/24 revealed the following: -On 8/2/24 at approximately 7:30 PM, Staff 25 (Former CNA) attempted to transfer Resident 33 using a mechanical lift. While lifting the resident and moving the lift so Resident 33 was over the bed, the wheel rolled over a metal strip on the floor causing the lift to jerk. The sling tilted, and Resident 33 fell out of the sling and onto the floor. -Staff 25 attempted to stop the resident from falling, reached for the resident's right arm, and inadvertently caused lacerations with his fingers. Resident 33 hit her/his head and sustained a laceration from the fall. -Staff 8 (LPN/Social Service Director) was notified immediately, assessed the resident, and managed the bleeding from Resident 33's head and right arm. The resident was able to speak and converse appropriately per her/his baseline. -The resident was transferred to the hospital for further evaluation and received sutures to her/his left forehead. An 8/3/24 Hospital Record revealed Resident 33 sustained a laceration to the left forehead, which required three sutures, and had an abrasion to her/his right forearm from falling out of a mechanical lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/17/24 at 1:19 PM, Staff 25 stated he recalled the incident with Resident 33 on 8/2/24. Staff 25 stated Resident 33 was dependent on staff for all ADL care needs and required two-person assistance with a mechanical lift for transfers. Staff 25 stated it was a busy night and he could not find any staff to assist him with the transfer, and he wanted to get the resident into bed. Staff 25 stated Resident 33 was in the mechanical lift and when he moved the lift, the leg of the lift caught on something on the floor, causing the sling to swing. He attempted to grab the resident's right arm but it was too late, and the resident fell to the floor, hitting her/his head. Staff 25 stated there was blood coming from the resident's head and she/he had a bruise on her/his right arm from him trying to stop the fall. Staff 25 immediately got Staff 8, who assessed the resident and stopped the bleeding. Staff 25 stated it was his fault and he felt terrible about the incident. Staff 25 stated he knew Resident 33 required two-person transfer assistance but he did not follow the care plan. On 12/18/24 at 10:23 AM, Staff 3 (Assistant Executive Director/Social Service) stated he was alerted of the incident and came into the facility. Staff 3 stated he learned Staff 25 transferred Resident 33 on his own and did not follow the care plan. Staff 3 stated Resident 33's laceration was visible and bleeding when he arrived. Staff 3 stated the resident was eventually sent out to the hospital to be evaluated further. Staff 3 stated It appeared to him the wheel of the mechanical lift got caught on a metal divider on the floor, which caused Resident 33 to be tossed out of her/his sling. The sling was evaluated and found to be functional. Staff 3 stated facility staff used a different sling after the 8/2/24 incident. Staff 3 stated in-service training and education were provided to all staff regarding following the care plan, and proper use of the mechanical lift and slings. On 12/18/24 at 2:19 PM, Staff 8 (LPN) and on 12/19/24 at 1:17 PM, Staff 2 (DNS) were present for an interview. Staff 8 stated Staff 25 attempted a mechanical lift transfer with Resident 33 without a second CNA present, which caused the resident to fall out of the sling and hit her/his head on the frame of the mechanical lift. The resident had bruising to her/his right arm from Staff 25 attempting to stop the fall out of the sling. Staff 8 stated Resident 33 was bleeding and he could not get the bleeding to stop. Staff 8 stated it was evidence the the laceration needed stitches. Staff 8 stated the resident had dementia and did not understand what happened. Staff 2 and Staff 8 stated training and in-service were provided to all staff regarding the incident. The deficient practice was determined to be past noncompliance as the facility addressed the deficient practice on 8/3/24 by completing the following actions: 1. Conducted a thorough investigation of the incident. 2. Educated Staff 25 to follow the care plan and was placed on a 90 day probationary period. 3. Provided staff education on proper use of two staff persons when using the mechanical lift and following resident care plans explicitly.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 36494 Based on interview and record review it was determined the facility failed to ensure CNAs received annual performance reviews for 5 of 5 randomly selected CNA staff (#s 6, 10, 14, 23 and 24) reviewed for staffing. This placed residents at risk for lack of care by competent staff. Findings include: On 12/18/24 at 10:00 AM, Staff 2 (DNS) was asked for the annual performance reviews for Staff 6, Staff 10, Staff 14, Staff 23 and Staff 24. On 12/18/24 at 12:52 PM, Staff 1 (Administrator) and Staff 2 were present for an interview. Staff 2 stated Staff 6, Staff 10, Staff 14, Staff 23 and Staff 24 did not have annual performance reviews completed. Staff 2 stated she did not provide annual performance reviews.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36494 Based on interview and record review it was determined the facility failed to ensure records were complete and accurate for 1 of 5 sampled residents (#12) reviewed for medications. This placed residents at risk for inaccurate medical records. Findings include: Resident 12 was admitted to the facility in 1/2024 with diagnoses including chronic heart failure and COPD (Chronic Obstructive Pulmonary Disease). a. A Physician Order dated 4/19/24, revealed the following: -Daily Weights were to be obtained every morning and staff were to contact the provider for the following weight gain related to heart failure. -Three pounds in 24 hours. -Five pounds in a week. -If weight falls less less then 195, notify the provider. A review of Resident 12's 11/2024 and 12/2024 TARs and Weights and Vitals Summary revealed the following: 11/2024: Resident 12's weight was consistently below 195 pounds. 12/2024: Resident 12's weight was below 195 pounds until 12/17/24, when her/his weight was 198.5. On 12/19/24 at 12:56 PM, and 12/20/24 at 8:37 AM, Staff 2 (DNS) stated the 4/18/24 physician order was inaccurate. Staff 2 stated the order needed to be updated because Resident 12's weight was consistently averaging in the 180s and the physician was aware of the resident's weight status b. A Physician Order dated 7/29/24, directed staff to administer seven units of insulin subcutaneously with meals for diabetes. Staff were to hold insulin for blood sugars less than 100 and were to notify the physician if blood sugars were less than 80 or greater than 350. A Physician Order dated 7/29/24, directed staff to administer insulin per sliding scale as followed: -201 - 250 administer one unit; -251 - 300 administer two units; -301 - 350 administer three units; -351 - 400 administer four units; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-401 - 450 administer five units; -451 administer six units and then notify the PCP after re-checking the resident in two hours related to diabetes. A review of the 12/2024 TARs revealed the resident had four instances where her/his blood sugar was greater than 350. A review of Resident 12's medical record revealed no evidence the physician was notified of the high blood sugars. On 12/19/24 at 12:56 PM, and 12/20/24 at 8:37 AM, Staff 2 (DNS) stated the 7/29/24 physician order was not intended to include contacting the physician if Resident 12's blood sugar was greater than 350. Staff 2 stated staff were to follow the 7/29/24 sliding scale order for when to notify the physician if the resident's blood sugar was greater than 451.