

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/10/2026
NAME OF PROVIDER OR SUPPLIER The Dalles Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review it was determined the facility failed to ensure resident mail was delivered to residents on Saturdays for 1 of 1 facility reviewed for resident council. This placed residents at risk for lack of timely written communication. Findings include: Resident 5 was admitted to the facility in 5/2024 with diagnoses including encephalopathy (a syndrome characterized by diffuse brain dysfunction). During a Resident Council meeting on 7/8/26 at 10:15 AM, Resident 5 stated she/he enjoyed receiving mail and didn't know mail was delivered on Saturdays. During an interview on 7/9/26 at 12:55 PM, Staff 20 (Activities Director) stated she delivered mail to residents Monday through Friday but was unsure of who distributed mail on Saturdays. On 7/9/26 at 1:12 PM, Staff 1 (Administrator) confirmed mail was not distributed to residents on Saturdays.		

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review it was determined the facility failed to ensure residents as needed psychotropic medications were discontinued as required for 1 of 5 sampled residents (#2) reviewed for medications. This placed residents at risk for adverse side effects of medication. Findings include: The facility's 6/2025 Psychoactive Medication Policy lists new orders for PRN (as needed) psychoactive medications (mood changing medications) were to expire after 14 days or required justification for continued use for a specific period. Resident 2 was admitted to the facility in 8/2025 with diagnoses including dementia and maxillofacial fracture (fracture of the upper jawbone). The 4/16/26 Significant Change MDS indicated Resident 2 was taking an antipsychotic and an antidepressant. Resident 2's physician orders revealed the resident was prescribed Lorazepam (an antianxiety medication) 0.5 MG as needed (PRN) in the evening for severe anxiety/agitation with a start date of 3/27/26 and a stop date of 5/5/26. Resident 2's medication administration records revealed the resident was last administered 0.5 MG of Lorazepam on 4/22/26. The pharmacist's 4/21/26 MRR indicated the PRN 0.5 MG of Lorazepam had been active over 14 days and requested the order to be discontinued or extended for a specific time with written justification for the extension. On 7/8/26 at 10:14 AM Staff 7 (Pharmacist) stated he did not see a response from the physician for the PRN Lorazepam. On 7/9/26 at 12:18 PM Staff 4 (RNCM) stated she had not obtained a response because she had seen an order for PRN Lorazepam with a stop date for 3/27/26 and missed the PRN order which had started on the same day but at a lower dose. Staff 4 confirmed the order should have had a 14-day stop date from the start date. On 7/10/26 at 9:15 AM Staff 2 (DNS) confirmed the 0.5 MG Lorazepam PRN order should have had a 14-day stop date.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review it was determined the facility failed to ensure pharmacist recommendations were considered for 1 of 5 sampled residents (#2) reviewed for medications. This placed residents at risk for unnecessary medication. Findings include: A 3/2019 Medication Regimen Review (MRR) Policy indicated the pharmacist completed the MRR monthly. The facility and the attending physician were to respond to the pharmacist's recommendation within a two-to-four-week timeframe. Resident 2 was admitted to the facility in 8/2025 with diagnoses including dementia and nausea. Resident 2's physician orders revealed the resident was prescribed Ondansetron 8mg every 6 hours PRN for nausea starting 5/7/26 and Ondansetron 8 mg once a day for nausea starting 5/8/26. The pharmacist's 5/19/26 MRR identified 24mg per day was the max dose for Ondansetron and asked the physician if they wished to reduce the Ondansetron to 8mg twice per day PRN. No documentation was found in the clinical record regarding a response from the physician. On 7/8/26 at 10:14 AM Staff 7 (Pharmacist) stated he had not received a response from the physician related to the 5/19/26 MRR recommendation. On 7/9/26 at 12:18 PM Staff 4 (RNCM) and Staff 5 (RNCM) stated the RNCM's and Staff 2 (DNS) received the MRR recommendations from the pharmacist and the recommendations were either faxed, emailed, or put in designated spots in the facility for the physician to review. Staff 4 stated she did not have any responses back from the physician regarding the Ondansetron recommendation. On 7/10/26 at 9:15 AM Staff 2 stated pharmacy recommendations should be acted upon timely and confirmed the facility did not have a response from the physician for the 5/19/26 pharmacist recommendation.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 5 sampled residents (#24) observed for safe medication administration. This placed residents at risk for inadequate symptom management. The 2026 Davis's Drug Guide indicated Extended Release (ER) oral medications should not be crushed. Resident 24 was admitted to the facility in 5/2026 with diagnoses including Parkinsonism (a neurological disorder characterized by abnormal body movements and impaired muscle control). Resident 24's 7/26/26 Physician Orders included the following: -carbidopa-levodopa (an antiparkinson agent) ER 50-200 mg tablet, to be administered twice daily for generalized weakness. -There was no order in place to crush oral medications. Resident 24's 6/2026 and 7/2026 MARs indicated Staff 9 (CMA) administered Resident 24's carbidopa-levodopa ER oral medication 29 times between 6/8/26 and 7/8/26. On 7/8/26 at 6:30 AM Staff 9 was observed administering a carbidopa-levodopa ER tablet orally in crushed form. On 7/8/26 at 8:10 AM Staff 9 acknowledged they crushed the carbidopa-levodopa ER tablet and administered it to Resident 24. Staff 9 stated they did not see the medication was in ER form in the residents' orders and acknowledged there was not an order in place to crush the medication before administration. Staff 9 stated the medication should not have been crushed. Staff 9 indicated they began administering Resident 24's carbidopa-levodopa ER oral medication in crushed form approximately one month ago. On 7/8/26 at 12:20 PM Staff 8 (Nurse Practitioner) stated carbidopa-levodopa ER oral medication should not be crushed because ER medications are formulated to release medication gradually over time. Staff 8 stated crushing the medication could reduce its prolonged effectiveness, resulting in a wearing off effect and poorly controlled Parkinson's symptoms. On 7/8/26 at 12:41 PM Staff 7 (Pharmacist) stated ER medications should not be crushed. Staff 7 stated ER oral medications are designed to release medication over time and residents who repeatedly received crushed ER oral medication may not receive the full effect of the medication. Staff 7 stated this placed residents at risk for experiencing an increase in Parkinson's symptoms. On 7/9/26 at 12:22 PM Staff 2 (DNS) acknowledged extended-release medications should not be crushed and stated staff should not crush and administer ER oral medications.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to offer pneumococcal immunizations for 1 of 5 sampled residents (#2) reviewed for immunizations. This placed residents at risk for pneumonia. Findings include: Review of the facility's Pneumococcal Vaccine policy, dated 6/19/25, instructed the facility to follow the CDC Pneumococcal Vaccine Timing for Adults guide to determine appropriate vaccination and cadence. CDC's Pneumococcal Vaccine Timing for Adults, dated March 2025, revealed there were 4 types of pneumococcal conjugate vaccine (PCV13, PCV15, PCV20, and PCV21) and pneumococcal polysaccharide vaccine (PPSV23) available in the United States. For adults 65 years or older who have only received PCV13 and PPSV23 after age [AGE] years old, CDC recommended offering the PCV20 or the PCV21 at least five years after receiving the PCV13 and PPSV23. Shared clinical decision making was described to be completed together with the patient. Resident 2 was admitted to the facility in 8/2025 with diagnoses including dementia and squamous cell carcinoma (a type of skin cancer). Resident 2's clinical records revealed the resident was over [AGE] years old and last received the PCV 13 on 10/20/15 and the PPSV23 on 10/4/17. There was no evidence found in the clinical record to verify Resident 2 was offered or allowed to decline the PCV20 or PCV21. On 6/4/26 12:46 PM Staff 10 (Infection Preventionist) and Staff 2 (DNS) stated they used the CDC's PneumoRecs VaxAdvisor site to assist with confirming what and when vaccinations were due. Staff 2 and Staff 10 confirmed Resident 2 was due for pneumococcal vaccination and was not offered the PCV20 or PCV21 vaccine. Staff 2 confirmed she was unable to provide documentation to demonstrate a clinical decision to not offer the pneumococcal vaccine was discussed with Resident 2 or Resident 2's representative.		