STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385207	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dallas Retirement Village Health Center	377 NW Jasper Street Dallas, OR 97338

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42271 Based on observation, interview, and record review it was determined the facility failed to protect a resident's right to be free from physical abuse by staff for 1 of 4 sampled resident (#1) reviewed for abuse. This placed residents at risk for physical abuse. Findings include. On 11/4/24, the State Survey Agency received a public complaint which alleged Resident 1 was treated roughly and slapped by a CNA. Resident 1 was admitted to the facility in 9/2024, with diagnoses including post-traumatic hydrocephalus (traumatic brain injury, TBI). A 9/18/24 Admission care plan indicated Resident 1 had left sided weakness, required substantial-total assist with bed mobility and spoke Spanish. A 9/19/24 Admission MDS indicated the resident had severe cognitive impairment. On 11/7/24 at 9:41 AM, Resident 1 was observed to be resting comfortably in bed with bolsters on each side of the bed, the bed was lowered, fall mats were in place, the bed was up against the wall, and the call light was within reach. The residents spouse was in the room. Resident 1 was sleeping off and on with no signs of distress. On 11/7/24 at 1:56 PM, Staff 5 (CNA) stated if he was aware a resident was being abused he would make sure the resident was safe and report it to the nurse. On 11/7/24 at 2:08 PM, Staff 7 (RN) stated if she was aware a resident was being abused she would make sure the resident was safe, alert the Administrator and file a report with the state. On 11/7/24 at 2:44 PM, Staff 8 (CNA) stated she always worked on the skilled side of the facility and enjoyed working double shifts from evenings to night shift. Staff 8 stated if residents were bed bound, she was able to turn residents by herself. Staff 8 stated she had never been rough with Resident 1, never caused physical abuse to Resident 1 and had never slapped Resident 1. On 11/8/24 at 1:17 PM, Staff 9 (CNA) assisted with Spanish translation. Staff 9 asked Resident 1 (in Spanish) if she/he felt safe at the facility. Resident 1 answered 'No' and when asked why, Resident 1 was unable to answer. Resident 1's demeanor was calm. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, the State Survey Agency received a public complaint. The anonymous complainant included video footage of Resident 1 and Staff 8 on 10/27/24. On 11/13/24 at 12:58 PM, Witness 3 (Client Care Surveyor, Interpreter) interviewed Resident 1 via phone with the surveyor in the room. Resident 1 stated she/he was aware there was a camera in the room. When Resident 1 was asked if any of the staff had been rough with her/him, Resident 1 started to cry and was upset. Resident 1 stated she/he did not feel safe in the facility. On 11/13/24 at 2:39 PM, Staff 8 (CNA) stated Resident 1 was a 'heavy turn' and stated most of the time she was able to turn Resident 1 in the bed by herself. Staff 8 stated she was not rough with the resident when she provided care and did not slap the resident. God no I wouldn't slap a resident. Staff 8 was made aware Resident 1 had a camera in her/his room on the same day of her interview. On 11/13/24 at 2:39 PM, the video footage of Resident 1 taken on 10/27/24 at 2:13 AM was reviewed with Staff 8 (CNA). Staff 8 denied the CNA in the room was her. I don't have a scrub top like that. I have never treated a patient like that. Look, that is not my hair! The 10/27/24 staff schedule revealed Staff 8 (CNA) worked a double shift from evening shift to night shift. Staff 8 was assigned to Resident 1 in room [ROOM NUMBER]. On 11/13/24 at 2:45 PM, the video was reviewed by the surveyor, Staff 1 (Administrator) and Staff 2 (DNS). Staff 1 and Staff 2 identified Resident 1 and Staff 8 (CNA) in the video. The video revealed Resident 1 in bed on 10/27/24 at 2:13 AM. Staff 8 was observed to forcefully and roughly push Resident 1's legs to the side in the bed while Staff 8 performed a linen change. Resident 1 can be heard saying, No, no, no and Ai yai yai (Spanish for oh no or oh my god) while Staff 8 pushed Resident 1's legs side to side. At one point, Staff 8 used a slapping motion in the direction of Resident 1's face. The slap was heard on the audio. Staff 8 was then seen grabbing Resident 1's right hand and arm and pushing it away. On 11/13/24 at 2:49 PM, Staff 1 (Administrator), Staff 2 (DNS) and the state surveyor, reviewed facility video footage taken from the hallway on 10/27/24 between 2:00 AM and 2:30AM. Staff 8 (CNA) was observed to walk out of room [ROOM NUMBER] where Resident 1 resided. On 11/13/24 at 3:20 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged Staff 8 (CNA) was rough, aggressive and made a 'slapping motion' at Resident 1. Staff 1 stated the care provided in the video by Staff 8 was not conducted according to the facility standards and expectations. Staff 8 was sent home.