

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Dallas Retirement Village Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34702</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure medication storage temperatures were logged and failed to ensure proper labeling of biologicals for 3 of 3 medication storage refrigerators reviewed for safe medication storage. This placed residents at risk for receiving medications with reduced efficacy. Findings include:</p> <p>1. On 12/4/24 at 9:15 AM, one open, undated vial of tuberculin (used for the testing in the diagnosis of Tuberculosis) was observed in the nurses' station three medication room refrigerator. The manufacturer's instructions indicated to discard the medication 30 days after opening.</p> <p>On 12/4/24 at 9:15 AM, Staff 11 (LPN) acknowledged the vial of tuberculin was open and not labeled with an open date.</p> <p>On 12/4/24 at 12:12 PM, Staff 2 (DNS) stated the expectation was for staff to label tuberculin with an open date.</p> <p>2. On 12/4/24 at 8:56 AM, the nurses' station one hall medication room refrigerator temperature logs was observed to be blank from 11/1/24 through 11/25/24.</p> <p>On 12/4/24 at 8:56 AM, Staff 12 (LPN) acknowledged the temperature logs were blank on the identified dates.</p> <p>On 12/4/24 at 12:12 PM, Staff 2 (DNS) stated the expectation was for the medication room refrigerator temperature to be checked and logged twice daily. Staff 2 acknowledged there were no temperatures documented from 11/1/24 through 11/25/24.</p> <p>3. On 12/4/24 at 9:08 AM, the nurses' station two hall medication room refrigerator temperature logs was observed to be blank on 11/17/24 and 11/29/24.</p> <p>On 12/4/24 at 9:08 AM, Staff 13 (RNCM) acknowledged the temperature logs were blank on the identified dates.</p> <p>(continued on next page)</p>

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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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/4/24 at 12:12 PM, Staff 2 (DNS) stated the expectation was for the medication room refrigerator temperature to be checked and logged twice daily. Staff 2 acknowledged there were no temperatures documented on 11/17/24 and 11/29/24.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42270</p> <p>Based on observation and interview it was determined the facility failed to serve, store, and label food in a sanitary manner for 1 of 2 dining rooms and 1 of 2 facility refrigerators observed for dining. This placed residents at risk for contamination and at risk for food borne illness. Findings include:</p> <p>1. On 12/4/24 at 1:00 PM, Staff 15 (Dietary Aid) was observed serving lunch in the second floor kitchen. While Staff 15 served a meal ticket fell off the serving station into the dining room. Staff 15 walked out of the kitchen, picked up the meal ticket with her gloved hand, returned to the kitchen with the meal ticket, placed it back on the service station, and touched multiple service items while wearing the same gloves. Staff 15 confirmed the meal ticket should not have been placed back on the service station once it fell on the floor and her gloves should have been changed after she touched the floor.</p> <p>On 12/4/24 at 1:43 PM, Staff 16 (Dietary Manager) confirmed once the meal ticket fell it should not be placed back on the service station.</p> <p>50928</p> <p>2. On 12/2/24 at 10:25 AM, a communal refrigerator in the facility's pantry area was observed with the following:</p> <p>-One clear container filled with meat covered in gravy with no date.</p> <p>-One clear container with a red top containing left over white cake with white and chocolate frosting with no date.</p> <p>On 12/2/24 at 10:32 AM, Staff 1 (Administrator) stated it was her expectation food items were to be dated and labeled with the residents room number in which the item belonged to.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure community use CBG glucometers were properly cleaned and sanitized between resident use, failed to follow transmission based precautions, and failed to process laundry to produce hygienically clean laundry to prevent the spread of infection for 4 of 6 sampled residents (#s 33, 80, 83, and 84) and 1 of 1 laundry room reviewed for infection control. This placed residents at risk for bloodborne illness, exposure to infections, and contaminated laundry. Findings include:</p> <p>1. The facility's 3/2024 Blood Glucose Monitoring policy indicated to follow the manufacturer instructions for cleaning and disinfection of the meter.</p> <p>The Even Care G3 blood glucose monitoring system manufacturer instructions indicated to disinfect the meter with EPA-registered wipes.</p> <p>Resident 80 admitted to the facility in 2023 with diagnoses including diabetes.</p> <p>On 12/2/24 at 11:34 AM, Staff 14 (LPN) was observed to obtain a CBG from Resident 80. Staff 14 exited the room and cleaned the glucometer with alcohol wipes. Staff 14 stated she used alcohol wipes on a regular basis to clean the glucometer. Staff 14 stated she was assigned rooms 130-144 and the community use glucometer was used for five different residents on the hall.</p> <p>On 12/2/24 at 12:28 PM and at 1:00 PM, Staff 11 (LPN) stated she already completed resident CBG checks for the day and was assigned rooms 201-216. Staff 11 stated she primarily used alcohol wipes to clean the glucometer and the community use glucometer was used for three different residents on the hall.</p> <p>On 12/2/24 at 12:03 PM and on 12/3/24 at 9:27 AM, Staff 2 (DNS) stated the expectation was for staff to use EPA wipes between every glucometer use and ensure proper dwell times were reached.</p> <p>42270</p> <p>2. Resident 33 admitted to the facility in 6/2020, with diagnoses including lung cancer.</p> <p>On 12/02/24 at 2:18 PM, Resident 33's room was observed to have a sign which indicated staff were to follow enhanced barrier precautions when providing high contact activities, there was a cart outside the door which contained gloves, masks, and gowns.</p> <p>On 12/3/24 at 1:16 PM, Staff 17 (CNA) entered Resident 33's room and assisted her/him in using a bedpan. Staff 17 wore gloves and a mask but did not wear an isolation gown.</p> <p>On 12/3/24 at 1:21 PM, Staff 17 exited Resident 33's room, confirmed she assisted her/him with toileting. Staff 17 stated she knew Resident 33 required additional precautions previously, but she was told Resident 33 no longer needed the additional precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/4/24 at 9:50 AM, Staff 18 (CNA) entered Resident 33's room and assisted her/him in using the toilet. Staff 18 wore a mask and gloves but did not wear an isolation gown.</p> <p>On 12/4/24 at 10:01 AM, Staff 18 was asked about Resident 33's enhanced barrier precautions, she stated the staff were to wash their hands instead of sanitizing, but was not aware of the need to wear a gown during any care activities.</p> <p>On 12/4/24 at 2:20 PM, Staff 3 (Assistant Director of Nurses) stated the staff were to wear a gown, gloves and mask when they provided high contact care such as toileting for all residents on enhanced barrier precautions. Staff 3 confirmed Resident 33 was on enhanced barrier precautions and the staff should have worn gloves, gown, and a mask when they assisted her/him with toileting.</p> <p>47005</p> <p>3. Resident 83 admitted to the facility on ,d+[DATE], with diagnoses including bilateral post-surgical femoral artery resection and repair.</p> <p>On 12/1/24 Resident 83 tested positive for COVID and was placed on Contact and Droplet Precautions, signage at the door and personal protective equipment (PPE) cart was placed outside of the resident's door.</p> <p>On 12/3/24 at 1:16 PM, observed Staff 19 (CNA) exit a resident room while wearing a face mask without completing hand hygiene and retrieved a lunch tray for Resident 83. Staff 19 donned gown and gloves and entered Resident 83's room. Staff 19 exited the room, doffed gown and gloves, kept the same face mask and went back to retrieve another lunch tray to deliver.</p> <p>On 12/3/24 at 1:30 PM, Staff 19 acknowledged he should have sanitized his hands before and after handling the foods trays, worn full PPE and changed his face mask.</p> <p>On 12/6/24 at 9:53 AM, Staff 2 (DNS) stated she expected all staff to complete hand hygiene before and after entering a resident room and wear full PPE when entering an isolation room to decrease the spread of COVID in the facility.</p> <p>4. Resident 84 admitted to the facility on ,d+[DATE], with diagnosis including clostridioides difficile (C. diff).</p> <p>On 11/25/24 Resident 84 tested positive for COVID and was placed on Contact and Droplet Precautions, signage was placed on the resident's door, and personal protective equipment (PPE) cart was placed outside of the resident's door.</p> <p>On 12/4/24 at 10:04 AM, Staff 20 (RN) was observed to place her face mask on the PPE cart without a barrier and entered the isolation room on the COVID hall. Staff 20 exited Resident 84's room and donned the same face mask she had put on the PPE cart.</p> <p>On 12/4/24 at 10:10 AM, Staff 20 stated she should have put on a new face mask after exiting Resident 84's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/6/24 at 9:53 AM, Staff 2 (DNS) stated she expected all staff to use and wear proper PPE at all times to decrease the spread of COVID in the facility.</p> <p>48830</p> <p>5. According to the Center for Disease Control and Prevention: Guidelines for Environmental Control in Healthcare Facilities (2003); Laundry and Bedding Section G.II.D, damp laundry was not to be left in machines overnight.</p> <p>On 12/4/24 at 1:34 PM, Staff 8 (Laundry) stated his shift ended at 10:30 PM and he had the last shift of the day. Staff 8 stated when wet laundry was not completed in the washing machine at the end of his shift, he left the wet laundry in the washing machine overnight.</p> <p>On 12/4/24 at 1:38 PM, Staff 9 (Laundry) stated her shift started at 5:30 AM and she transferred the wet laundry to the dryer and did not rewash the laundry.</p> <p>On 12/5/24 at 1:24 PM, Staff 10 (Environmental Services Department Manager) stated wet laundry was left in the washing machine overnight and was placed in the dryer the next morning. The wet laundry was never rewash as it would take too long to do so.</p> <p>On 12/5/24 at 1:37 PM, Staff 1 (Administrator) stated she was unaware of a laundry policy regarding damp laundry left in the washing machine overnight.</p>		