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	04/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to disinfect reusable resident equipment between residents for 2 of 6 halls reviewed for infection control and failed to ensure staff implemented proper hand hygiene while assisting residents with meals 1 of 2 dining rooms reviewed for dining observation. This placed residents at risk for exposure to infections and illness from cross contamination. Findings include: 1. The facility's Disinfection of Resident Care Items and Equipment policy revised 11/2025 stated: Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). On 4/6/26 at 9:39 AM Staff 7 (CNA) exited room [ROOM NUMBER] with a mechanical lift then took the mechanical lift to room [ROOM NUMBER] without cleaning and disinfecting it. At 9:47 AM Staff 7 left room [ROOM NUMBER] and parked the mechanical lift in the hallway without cleaning and disinfecting it. Staff 7 stated the mechanical lift was not cleaned then but another staff member came through during the day and wiped off the lifts. On 4/8/26 at 3:19 PM Staff 2 (DNS) stated mechanical lifts were reusable equipment and were to be disinfected between each resident. 2. On 4/9/26 at 12:36 PM Staff 11 (CNA) utilized a ceiling-mounted lift device to transfer a resident in room [ROOM NUMBER]. At 12:45 PM Staff 11 put the lift onto a cart, moved it into the hallway, and left without cleaning the lift. At 12:48 PM Staff 12 (CNA) moved the same ceiling lift cart into room [ROOM NUMBER] to use with a different resident. Staff 12 was stopped by the surveyor and notified the ceiling lift was not cleaned after it was last used. On 4/9/26 at 12:50 PM Staff 12 stated the ceiling lifts were to be cleaned after each use and he assumed the lift was clean because it was in the hallway. On 4/9/26 at 12:51 PM Staff 11 (CNA) confirmed she did not clean the lift before placing it in the hallway. Staff 11 stated ceiling lifts were to be cleaned after each use. On 4/10/26 at 10:24 AM Staff 2 (DNS) stated ceiling lift devices were to be cleaned after every use prior to placing them in the facility hallway. 3. During a breakfast dining observation on 4/6/26 at 8:12 AM Staff 23 (CNA) was observed to assist Resident 35 with drinking from a straw. Staff 23 used his hand to adjust the straw up and down and held the straw to Resident 35's mouth. Staff 23 then, without sanitizing his hands, assisted Resident 43 with eating yogurt from a spoon and wiped her/his mouth with a napkin. Staff 23 returned to Resident 35 and assisted her/him with eating eggs from a spoon, without sanitizing his hands. (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/6/26 at 8:48 AM, Staff 23 stated he was not expected to sanitize his hands between residents while assisting with eating unless he got up from the table. Staff 23 acknowledged he did not sanitize his hands while he assisted Resident 35 and 43. On 4/6/26 at 8:53 AM, Staff 2 (DNS) stated staff were expected to perform hand hygiene between assisting residents with eating when food, straws, or the resident's face were touched.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to ensure a resident or resident representative was provided a bed hold policy for 1 of 2 sampled residents (#8) reviewed for hospitalization. This placed residents at risk for lack of information regarding their right to return to the facility. Findings include: Resident 8 was admitted to the facility in 4/2025 with a diagnosis of a stroke. Resident 8's 10/24/25 Quarterly MDS revealed she/he was moderately cognitively impaired. Resident 8's Progress Notes revealed on 11/28/25 she/he was admitted to the hospital. Resident 8's clinical record did not reveal she/he or her/his representative was provided bed hold information. On 4/6/26 at 11:21 AM Witness 3 (Family) stated in 11/2025 when Resident 8 was admitted to the hospital, she was not provided information related to a bed hold. On 4/8/26 at 10:10 AM Staff 14 (LPN) stated when residents were transferred to the hospital, bed hold information was placed in a packet, and provided to the transportation team to deliver to the hospital staff. Staff 14 stated she did not follow up with a resident or resident's representative to ensure they received the bed hold information. On 4/9/26 at 11:45 AM Staff 2 (DNS) stated when a resident was transferred to the hospital, a transfer packet, including the bed hold policy, was sent with the resident. Staff 2 stated Staff 13 (Admissions Director) reviewed the bed hold policy with the resident or resident's representative if a resident was admitted to the hospital. On 4/9/26 at 11:50 PM Staff 13 stated she followed up with residents or residents' representatives when they were admitted to the hospital, and then she made a note in a resident's clinical record. Staff 13 stated she did not recall if she/he followed up with Resident 8 or her/his family. On 4/10/26 at 10:41 AM Staff 1 (Administrator) stated when a resident who resided on the long-term care unit was admitted to the hospital they were always allowed back to the facility. Staff 1 also stated the bed hold information was more directed toward the skilled residents.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to develop a baseline care plan within 48 hours of admission for 1 of 3 sampled residents (#59) reviewed for falls. This placed residents at risk for injury from falls. Findings include: The facility's Baseline Care Plan policy dated 1/2026 stated, a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission.Resident 59 admitted to the facility on [DATE] with a diagnosis of nondisplaced fracture of right femur. Review of Resident 59's Baseline Care Plan revealed it was completed and reviewed with the resident on 3/30/26.On 4/10/26 at 10:02 AM Staff 20 (RNCM) stated baseline care plans for newly admitted residents were finalized within 72 hours of admission. On 4/10/26 at 11:38 AM Staff 2 (DNS) acknowledged Resident 59's Baseline Care Plan was not completed timely and needed to be finalized within 48 hours of her/his 3/27/26 admission.

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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. Based on interview and record review it was determined the facility failed to obtain physician orders for treatment of a change in skin impairment for 1 of 5 sampled residents (#80) reviewed for ADLs. This placed residents at risk for a delay in treatment. Findings include:Resident 80 was admitted to the facility in 4/2025 with diagnoses including depression and anxiety.The 10/2/25 Quarterly MDS indicated Resident 80 had a BIMS score of 13 which indicated the resident was cognitively intact.A 10/22/25 Physician Order revealed Resident 80 had erythema (abnormal redness under the skin) under her/his neck fold. Staff were to monitor the skin impairment every shift and notify the provider if the area deteriorated.A 12/3/25 Progress Note by Staff 8 (LPN) revealed Resident 80's erythema under the neck fold showed signs of deterioration including increased size and was tender to the touch. Staff 8 notified the provider and waited for a response.A review of Resident 80's Provider Progress Notes on 12/3/25, 12/5/25, and 12/7/25 revealed no response from Staff 8's notification related to the deterioration of erythema under Resident 80's neck fold.A review of Resident 80's progress notes revealed no follow-up notes related to a response from the provider or any further follow up calls placed to the provider to obtain further directions.A review of Resident 80's 12/2025 TAR revealed no new treatments for the deterioration of erythema under Resident 80's neck fold. On 4/10/26 at 11:15 AM Staff 8 stated he did not recall the 12/3/25 progress note or if the provider ever responded.On 4/10/26 at 11:45 AM Staff 2 (DNS) stated she expected staff to follow up with the provider the next day if a response was not received. Staff 2 confirmed there was no follow up to the provider completed for Resident 80's deterioration of erythema under her/his neck fold.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to implement appropriate transfer interventions to prevent falls for 1 of 3 sampled residents (#59) reviewed for falls. This placed residents at risk for injury. Findings include: Resident 59 admitted to the facility on [DATE] with a diagnosis of nondisplaced fracture of right femur. Review of Resident 59's Care Plan initiated 3/30/26 revealed nursing staff were to use a ceiling lift for transfers. Resident 59's Care Plan initiated 4/1/26 also revealed the resident was only to ambulate with therapy staff. A 3/31/26 Functional Abilities Evaluation revealed Resident 59 was dependent on facility staff for transfers. A 3/31/26 Incident Report indicated Resident 59 had a witnessed fall without injury in her/his room when Staff 19 (CNA) attempted to ambulate the resident with a front wheel walker and gait belt. A statement from Staff 19 revealed Resident 59 lost her/his balance during a transfer and was guided to the ground with low impact. A 3/31/26 Nursing Progress Note indicated Resident 59's care plan directed nursing staff to use a ceiling lift for transfers and the resident was only to ambulate with therapy staff. On 4/6/26 at 10:05 AM, Resident 59 stated she/he fell during a standing transfer with nursing staff in her/his room. On 4/9/26 at 12:02 PM and 4/10/26 at 10:39 AM attempts to reach Staff 19 were unsuccessful. On 4/9/26 at 1:39 PM Staff 18 (RN) stated Staff 19 told her he did not check Resident's 59 care plan before he attempted to transfer the resident. On 4/10/26 at 10:09 AM Staff 20 (RNCM) confirmed Resident 59's care plan directed nursing staff to use a ceiling lift to assist Resident 59 with transfers on 3/31/26, and the resident fell on 3/31/26 when her/his care plan was not followed by nursing staff.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review it was determined the facility failed to ensure staff assisted a resident with toileting for 1 of 1 sampled resident (#67) reviewed for incontinence. This placed residents at risk for increased incontinence and lack of dignity. Findings include:Resident 67 was readmitted to the facility in 4/2023 with a diagnosis of chronic kidney disease. Resident 67's Care Plan revised on 4/2/26 revealed she/he had an ADL self-care deficit. Resident 67 was identified to be mostly incontinent of bowel and bladder, occasionally used a bedside commode for toileting, and required the use of a mechanical lift for transfers. On 4/7/26 at 12:45 PM Staff 15 (CNA) was observed to enter Resident 67's room. Resident 67 stated she/he had to go to the bathroom. Staff 15 informed Resident 67 that she/he had an incontinent brief on and he would assist with incontinent care after lunch. Staff 15 was then observed to exit Resident 67's room and was observed to distribute other residents' meal trays. Resident 67 was observed to attempt to stand and this surveyor notified Staff 15 of Resident 67's attempt to self-transfer. When Staff 15 re-entered Resident 67's room she/he was located in her/his bathroom. On 4/8/26 at 8:15 AM Staff 15 stated Resident 67 did not always like to use the bedpan, was usually incontinent, and did not walk for at least three weeks. Staff 15 also stated on 4/7/26 he had to finish distributing other residents' meal trays and informed Resident 67 he would assist her/him with incontinent care after lunch. On 4/9/26 at 12:08 PM Staff 2 (DNS) stated if there were two staff in the hall, one staff should assist residents with toileting upon their request. On 4/10/26 at 11:20 AM Staff 1 (Administrator) stated a resident should be assisted with toileting when requested.