STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385257	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon Veterans Home	700 Veterans Drive 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 0600 Level of Harm - 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** Based on observation, interview and record review it was determined the facility failed to protect the resident's right to be free from physical abuse for 1 of 10 sampled residents (#26) reviewed for abuse. This placed residents at risk for physical harm. Findings include:The facilities Resident Freedom from Abuse Policy revised 10/7/24 stated the following:-The facility would prevent and prohibit abuse and ensure residents were provided with a safe environment.-Resident-to-Resident abuse included the willful or non-willful infliction of injury resulting in physical harm.Resident 26 was admitted to the facility in 6/2023 with diagnoses including depression.Resident 26's 11/30/25 Annual MDS revealed she/he had a BIMS of 14, which indicated the resident was cognitively intact. Resident 7 was admitted to the facility in 5/2025 with diagnoses including post-traumatic stress disorder and depression.Resident 7's 4/24/26 Annual MDS revealed she/he had a BIMS of 14, which indicated the resident was cognitively intact. A Facility Reported Incident dated 4/27/26 indicated a physical altercation occurred in the facility's smoking area between Resident 7 and Resident 26, which resulted in a bodily injury. Resident 26 received a laceration on her/his scalp from the physical altercation, which required the resident to be sent to the hospital.An Emergency Department Encounter dated 4/27/26 revealed Resident 26 was struck over the head with a cane and had a 1 cm laceration on her/his scalp, which required the placement of three staples. Resident 26 was discharged on 4/27/26 at 7:05 PM.A facility investigation dated 5/4/26 stated video footage was reviewed to determine the sequence of events of the physical altercation between Resident 7 and Resident 26. On 4/27/26 at 4:40 PM Resident 26 entered the facility's smoking area alone and Resident 7 entered afterward. Resident 7 proceeded to move within a foot of Resident 26 and attempted to strike Resident 26's right arm. During the physical altercation, Resident 7 struck Resident 26 in the head with a cane, which caused Resident 26 to bleed. At 4:51 PM, Staff 3 (RN) escorted Resident 26 out of the smoking area.The 5/4/26 facility investigation of the physical altercation stated the following:-Resident 7 was ordered bupropion (an antidepression medication) on 4/17/26 with a potential side effect of agitation. The medication was discontinued on 4/28/26. -Review of the video footage indicated Resident 7 acted with intent to cause physical harm to Resident 26.-Verbal provocation between Residents 7 and 26 was undetermined. -The investigative conclusion was Resident 7's actions appeared willful.On 6/23/26 at 10:23 AM, Resident 7 confirmed she/he was in a physical altercation with Resident 26. Resident 7 stated she/he caused Resident 26 to bleed. Resident 7 stated she/he had a tendency to fight in response to interpersonal conflict. Resident 7 acknowledged she/he made a mistake and stated, I should have turned around and walked out.On 6/23/26 at 11:10 AM, Resident 26 confirmed she/he was in a physical altercation with Resident 7. Resident 26 stated she/he was unaware why Resident 7 struck her/him with a cane. Resident 26 stated she/he was unable to recall if a verbal altercation preceded the physical altercation with Resident 7. On 6/24/26 at 2:00 PM, Resident 26 was observed in the dining room of [NAME] Unit with a small scar on her/his forehead. On 6/24/26 at 2:16 PM, Staff 3 (RN) confirmed he intervened in the physical altercation between Resident 7 and Resident 26. Staff 3 stated there were (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 0600 Level of Harm - Actual harm Residents Affected - Few	no other staff or residents who witnessed the physical altercation. Staff 3 stated Resident 26 did not have a history of physical altercations with other residents in the facility.On 6/25/26 at 2:11 PM, Staff 13 (RNCM) stated Resident 26 did not have a history of verbal altercations with other residents in the facility. On 6/26/26 at 10:52 AM, Staff 14 (RNCM) confirmed she reviewed the video footage of physical altercation between Resident 7 and Resident 26. Staff 14 stated Resident 26 was alone for a few minutes before Resident 7 entered the smoking area on 4/27/26. Staff 14 stated Resident 7 did not sustain any injuries from the physical altercation.On 6/26/26 at 11:12 AM, Staff 2 (Assistant DNS), Staff 13 and Staff 14 confirmed they were involved in the completion of the 5/4/26 facility investigation. Staff 2, Staff 13 and Staff 14 indicated Resident 7 acted willfully to inflict harm to Resident 26 on 4/27/26. Staff 2, Staff 13 and Staff 14 confirmed physical harm occurred to Resident 26 on 4/27/26 as a result of Resident 7's actions. The deficient practice was identified as Past Noncompliance based on the following:On 4/28/26, the deficient practice was identified by the facility and was corrected when the facility implemented a plan of correction. The Plan of Correction included the following:1. Resident 7 and Resident 26 were required to be supervised for all smoking activities until the facility was able to determine there was no potential for future occurrences.2. Resident 7's cane was removed and not returned until the facility was able to determine there was no potential for future occurrences.3. Staff were educated to provide increased monitoring for Resident 7 and 26 to ensure the safety of themselves and other residents.