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	03/14/2025

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 - 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. 40767 Based on interview and record review it was determined the facility failed to protect the resident's right to be free from physical abuse by Resident 76 for 1 of 3 sampled residents (#106) reviewed for physical abuse. This placed residents at risk for physical, mental, or psychosocial harm. Findings include: Resident 106 admitted to the facility in 2/2024 with diagnoses including heart failure and dementia. Resident 106 passed away on 11/2/24. Resident 76 admitted to the facility in 1/2023 with diagnoses including dementia and anxiety disorder. Resident 76's, Behavior Care Plan dated 4/24/23 indicated the resident expressed agitation with others, typically related to noise. Staff were to encourage Resident 76 to go to her/his room or another quiet area if there was music playing and she/he was getting agitated. A 9/17/24 Resident to Resident Conflict report indicated that day an altercation occurred in the residents' shared room. The report stated Resident 106 was choked by Resident 76. Staff reported hearing yelling coming from the room and when they arrived, they observed Resident 76 with both her/his arms around Resident 106's neck from behind. Resident 106's glasses were knocked off during the altercation. Staff separated the residents. The investigation indicated Resident 76 also struck a staff member across the face after being pulled away from Resident 106. Per resident interviews, Resident 76 asked resident 106 to turn off her/his radio, and Resident 106 told Resident 76 to Shut the hell up. Resident 76 did not recall the incident, but when details were provided, she/he did recall placing her/his hands on Resident 106. Resident 106 stated, I just wanted to listen to my radio. I try not to bother anyone. Resident 106 further stated Resident 76 was, going to kill me and [Resident 76] had [her/his] finger in my mouth then covered my nose and mouth with [her/his] hand. Resident 106 denied feeling afraid of Resident 76, but stated, I feel mad at [her/him]. Resident 106 sustained temporary redness to the back of her/his neck due to the incident. A 9/17/24 Wound Evaluation with a photo documented as Bruise indicated a reddened area to Resident 106's neck. A 9/18/24 nursing note completed by Staff 12 (RN) indicated Resident 106 no longer had a bruise on her/his neck. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Oregon Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Veterans Drive The Dalles, OR 97058	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 9/21/24 Wound Evaluation note with photo documented as Bruise indicated measurements of .27 cm x 1. 47 cm x 0.2 cm and indicated Resident 106's bruise resolved. On 3/12/25 at 10:12 AM Staff 12 stated she was not the nurse on duty for the 9/17/24 incident as the nurse no longer worked at the facility. Staff 12 stated she did alert charting after the incident and would consider the incident abuse. Staff 12 stated there were no further incidents between the residents. On 3/13/25 at 11:47 AM Staff 25 (CNA) stated she did not witness the 9/17/24 incident but heard the residents yelling and assisted after the incident. Staff 25 stated Resident 106 responded to the incident like what the heck just happened? On 3/13/25 at 8:46 AM Staff 6 (RNCM) stated Resident 106 was playing music on the boombox and which triggered Resident 76. Resident 106 was on her/his side of the room with her/his back to Resident 76 who was upset Resident 106 was not turning the music down. Resident 76 came up behind Resident 106 and wrapped her/his arm around Resident 106's neck. Resident 106 told Staff 6, [Resident 76] put [her/his] fingers in my mouth and reported that [woman/man] tried to kill me! Resident 106 sustained a red area behind her/his neck because Resident 76 was holding her/him close. Staff 6 stated the reddened area resolved on 9/21/24. Resident 106 reported some pain after the incident, but it was not long lasting. Survey determined the Past Noncompliance was corrected on 9/23/24 when the facility identified deficient practice and initiated corrections with no further incidents. The Plan of Action included; 1. Resident 76 was placed on 1:1 observation for 24 hours after the incident. 2. A room change was completed for Resident 106 on 9/17/24, down a different hall. 3. A room change to a private room was completed for Resident 76 on 9/23/24 4. Monitoring of both residents was immediately initiated. 5. The facility updated both resident care plans to prevent a re-occurence on 9/23/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40767 Based on interview and record review, it was determined the facility failed to report an allegation of sexual abuse to the State Survey Agency for 2 of 3 residents (#s 54 and 307) reviewed for sexual abuse. This placed residents at risk for a lack of protective measures to prevent further abuse. Findings include: 1. Resident 54 admitted to the facility in 4/2021 with diagnoses including diabetes and a leg fracture. Resident 108 admitted to the facility in 11/2022 with diagnoses including diabetes and PTSD. Resident 54's 9/16/24 St. Louis University Mental Status (SLUMS) Examination indicated the resident had a score of 16/30, indicating cognitive impairment or possible dementia. On 1/8/25 a public complaint was received indicating Resident 108 was known to inappropriately touch female residents during activities. Witness 2 (Complainant) stated Resident 108 put her/his hand up their shirts or down their pants. Witness 2 stated Resident 108 put her/his hand up Resident 54's shirt five or six months ago. There was no further information provided. On 3/11/25 at 1:19 PM and 3/13/25 at 9:42 AM Staff 17 (Activities) stated she witnessed Resident 108 grab Resident 54's breast over the resident's shoulder during an activity. Staff 17 stated the incident occurred months ago. At the time of the incident, Staff 17 separated the residents and reported the incident to Staff 23 (Former RNCM). No evidence was found to indicate the incident was reported to the State Survey Agency. On 3/12/25 at 2:17 PM and on 3/13/25 at 10:18 AM attempts were made to contact Staff 23, but calls were not returned. On 3/13/25 at 12:09 PM Staff 1 (Administrator) stated she was not aware of the concerns regarding Resident 108 touching Resident 54's breast. Staff 1 acknowledged the incident was not reported to the State Survey Agency and stated she expected this type of incident to be reported. 2. Resident 307 admitted to the facility in 1/2024 with diagnoses including dementia and vascular Parkinsonism. Resident 307 passed away on 2/8/25. Resident 108 admitted to the facility in 11/2022 with diagnoses including diabetes and PTSD. Resident 307's 9/3/24 Annual MDS indicated the resident had moderately impaired cognition. The resident's 9/5/24 care plan indicated the resident had impaired cognitive function or impaired thought process related to the dementia diagnosis. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 a public complaint was received and the complainant (Witness 2) reported Resident 108 was known to inappropriately touch female residents during activities. Witness 2 stated Resident 108 put her/his hand up their shirts or down their pants. On 3/11/25 at 1:19 PM and 3/13/25 at 9:42 AM Staff 17 (Activities) stated months ago she witnessed Resident 108 touch Resident 307's breast during an activity. Staff 17 stated Resident 307 would encourage the behavior, but Resident 307 could not consent to the contact. Staff 17 stated she reported the incident to Staff 18 (Activities) and Staff 28 (Activities Director). No evidence was found to indicate the incident was reported to the State Survey Agency. On 3/13/25 at 12:09 PM Staff 1 (Administrator) stated she was not aware of the concerns regarding Resident 108 touching Resident 307's breast and acknowledged it was not reported to the State Survey Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40767 Based on interview and record review, it was determined the facility failed to thoroughly investigate an allegation of abuse for 3 of 6 sampled residents (#s 54, 106, and 307) reviewed for abuse. This placed residents at risk for lack of protective measures to prevent a reoccurrence. Findings include: The facility's 10/7/24 Freedom from Abuse and Abuse Investigation Policy stated, The facility will investigate all charges of abuse and report findings to the appropriate local and state agencies. 1. Resident 54 admitted to the facility in 4/2021 with diagnoses including diabetes and a leg fracture. Resident 108 admitted to the facility in 11/2022 with diagnoses including diabetes and PTSD. Resident 54's 9/16/24 St. Louis University Mental Status (SLUMS) Examination indicated the resident had a score of 16/30, indicating cognitive impairment or possible dementia. On 1/8/25 a public complaint was received indicating Resident 108 was known to inappropriately touch female residents during activities. Witness 2 (Complainant) stated Resident 108 would put her/his hand up their shirts or down their pants. Witness 2 stated five-six months prior, Resident 108 put her/his hand up Resident 54's shirt. There was no further information provided. On 3/11/25 at 1:19 PM and 3/13/25 at 9:42 AM Staff 17 (Activities) stated she witnessed Resident 108 grab Resident 54's breast over the resident's shoulder during an activity. Staff 17 stated the incident occurred months ago. At the time of the incident, Staff 17 moved Resident 108 away and reported the incident to Staff 23 (Former RNCM) who she believed talked with Resident 108 about the incident. On 3/13/25 at 12:09 PM Staff 1 (Administrator) stated she was not aware of the concerns regarding Resident 108 touching Resident 54's breast and this incident was not investigated prior to 3/13/25. 2. Resident 307 admitted to the facility in 1/2024 with diagnoses including dementia and vascular Parkinsonism. Resident 307 passed away on 2/8/25. Resident 307's 9/3/24 Annual MDS indicated the resident had moderately impaired cognition. Resident 108 admitted to the facility in 11/2022 with diagnoses including diabetes and PTSD. On 3/11/25 at 1:19 PM and 3/13/25 at 9:42 AM Staff 17 (Activities) stated she witnessed Resident 108 touch Resident 307's breast during an activity. Staff 17 stated Resident 307 would encourage the behavior, but the resident could not consent to the contact. The incident was reported to Staff 18 (Activities) and Staff 28 (Activities Director). On 3/13/25 at 12:09 PM Staff 1 (Administrator) stated she was not aware of the concern regarding Resident 108 touching Resident 307's breast and this incident was not investigated prior to 3/13/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The facility's 10/7/24 Freedom from Abuse and Abuse Investigation Policy, Abuse Investigation Guidelines stated, RCM (Resident Care Manager) will complete a full comprehensive and thorough investigation, including follow-up interviews with witnesses or persons involved. Resident 106 admitted to the facility in 2/2024 with diagnoses including heart failure and dementia. Resident 106 passed away on 11/2/24. Resident 76 admitted to the facility in 1/2023 with diagnoses including dementia and anxiety disorder. Resident 76's Behavior Care Plan dated 4/24/23 (prior to the incident), indicated the resident expressed agitation with others, typically related to noise. Staff were to encourage Resident 76 to go to her/his room or another quiet area if there is music playing and she/he is getting agitated. A facility reported incident dated 9/17/24 indicated an altercation occurred in the residents' shared room. Staff reported hearing yelling coming from the room and when they arrived, they observed Resident 76 with her/his arms around Resident 106's neck. Resident 76 asked Resident 106 to turn off her/his radio, and Resident 106 told Resident 76 to Shut the hell up. Resident 106 was sitting in her/his wheelchair with her/his back to Resident 76's side of the room when Resident 76 came up behind Resident 106 and wrapped her/his arms around Resident 106's neck. Resident 76 did not recall the incident, but when details were provided, she/he did recall placing her/his hands on Resident 106. Resident 106 stated Resident 76 was, going to kill me. [Resident 76] had [her/his] hand in my mouth then covered my nose and mouth with [her/his] hand. The investigation did not indicate if abuse was ruled out or verified. The investigation did not include staff or other witness statements prior to 3/14/25. On 3/13/25 at 8:46 AM Staff 6 (RNCM) stated she completed the investigation for the 9/17/24 incident. Staff 6 stated she normally interviewed staff as part of an investigation, but not including them was my mistake. When asked if abuse was determined to have occurred, Staff 6 stated it was determined the action was intentional from Resident 76. Staff 6 acknowledged the investigation required a determination to be documented.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 36494 Based on interview and record review it was determined the facility failed to accurately code MDS assessments for 5 of 5 sampled residents (#s 10, 23, 84, 97, and 103) reviewed for use of anticoagulants. This placed residents at risk for inaccurate medication assessments. Findings include: 1. Resident 10 admitted to the facility in 2018 with diagnoses including dementia and anxiety. The 10/29/24 and 1/21/25 Quarterly MDSes indicated Resident 10 received an anticoagulant medication. No evidence was found in Resident 10's clinical record to indicate she/he received an anticoagulant medication. On 3/14/25 at 9:40 AM, Staff 6 RNCM and at 11:15 AM, Staff 2 (DNS) were interviewed. Staff 6 stated she completed portions of the the MDS, including section N for medications. Staff 6 acknowledged Resident 10 was not on an anticoagulant and the 10/29/24 and 1/21/25 Quarterly MDS entries were inaccurate. Staff 2 (DNS) acknowledged Resident 10 was not on an anticoagulant medication. 2. Resident 23 admitted to the facility in 2024 with diagnoses including dementia and heart failure. The 11/30/24 and 2/3/25 Quarterly MDSes indicated Resident 23 received anticoagulant medication. No evidence was found in Resident 23's clinical record to indicate she/he received anticoagulant medication. On 3/14/25 at 9:40 AM, Staff 6 RNCM and at 11:15 AM, Staff 2 (DNS) were interviewed. Staff 6 stated she completed portions of the the MDS, including section N for medications. Staff 6 acknowledged Resident 23 was not on an anticoagulant and the 11/30/24 and 2/3/25 Quarterly MDSes were inaccurate. Staff 2 (DNS) acknowledged Resident 10 was not on an anticoagulant medication. 3. Resident 84 admitted to the facility in 2023 with diagnoses including dementia and a stroke. The 10/4/24 and 12/25/24 Quarterly MDSes indicated Resident 84 received anticoagulant medication. No evidence was found in Resident 84's clinical record to indicate she/he received an anticoagulant medication. On 3/14/25 at 9:40 AM, Staff 6 RNCM and at 11:15 AM, Staff 2 (DNS) were interviewed. Staff 6 stated she completed portions of the the MDS, including section N for medications. Staff 6 acknowledged Resident 84 was not on an anticoagulant and the 10/4/24 and 12/25/24 Quarterly MDSes were inaccurate. Staff 2 (DNS) acknowledged Resident 10 was not on an anticoagulant medication. 4. Resident 97 admitted to the facility in 2024 with diagnoses including a stroke. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/9/24 and 1/3/25 Quarterly MDS indicated Resident 97 received anticoagulant medication. No evidence was found in Resident 97's clinical record to indicate she/he received an anticoagulant medication. On 3/14/25 at 9:40 AM, Staff 6 RNCM and at 11:15 AM, Staff 2 (DNS) were interviewed. Staff 6 stated she completed portions of the the MDS, including section N for medications. Staff 6 acknowledged Resident 97 was not on an anticoagulant and the 10/9/24 and 1/3/25 Quarterly MDSes were inaccurate. Staff 2 (DNS) acknowledged Resident 10 was not on an anticoagulant medication. 5. Resident 103 admitted to the facility in 2/2025 with diagnoses including dementia and anxiety. The 2/20/25 Admission MDS indicated Resident 103 received anticoagulant medication. No evidence was found in Resident 103's clinical record to indicate she/he received an anticoagulant medication. On 3/14/25 at 9:40 AM, Staff 6 RNCM and at 11:15 AM, Staff 2 (DNS) were interviewed. Staff 6 stated she completed portions of the the MDS, including section N for medications. Staff 6 acknowledged Resident 103 was not on an anticoagulant and the 2/20/25 Admission MDS was inaccurate. Staff 2 (DNS) acknowledged Resident 10 was not on an anticoagulant medication.

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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. 48830 Based on interview and record review it was determined the facility failed to ensure physician orders related to bowel care were followed for 1 of 5 sampled residents (#79) reviewed for unnecessary medications. This placed residents at risk for adverse side effects of medications. Findings include: Resident 79 was admitted to the facility in 5/2023 with diagnosis including dementia and diabetes. A 7/16/24 physician order indicated Resident 79 was to receive a bowel care medication, Lactulose, once a day for constipation and the medication was to be held if the resident had two loose stools the day prior. A review of the 1/2025, 2/2025, and 3/2025 bowel records revealed the resident had two or more loose stools on the following dates: 1/3/25, 1/4/25, 1/10/25, 2/25/25, and 3/4/25. A review of the 1/2025, 2/2025, and 3/2025 MARs revealed Resident 79 was administered Lactulose on days it was to be held per the physician order on the following dates: 1/4/25, 1/5/25, 1/11/25, 2/26/25, and 3/5/25. On 3/13/25 at 2:39 PM Staff 4 (CMA) stated Resident 79 was consistent with having loose stools and she was aware of the physician order to hold the medication, Lactulose, for two loose stools the day prior. Staff 4 confirmed her initials on the MAR and acknowledged she administered Lactulose to the resident when it was to be held. On 3/13/25 at 3:01 PM Staff 5 (CMA) stated she was aware of Resident 79's physician order to hold Lactulose if the resident had two loose stools the day prior. Staff 5 stated at the start of her shift a report was run to identify Resident 79's bowel consistency and if the daily Lactulose physician order should be held. Staff 5 confirmed her initials on the MAR and acknowledged she administered Lactulose to the resident when it was to be held. On 3/14/25 at 9:43 AM and at 10:50 AM Staff 3 (RNCM) acknowledged Resident 79 was administered Lactulose on the identified dates and the dose should have been held. Staff 3 stated her expectation was for all staff to follow the resident's physician orders.