

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/26/2026
NAME OF PROVIDER OR SUPPLIER Oregon Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 antidepressant 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. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 385257	Facility ID: 385257 If continuation sheet Page 1 of 9

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 administer medications according to physician orders and failed to notify the physician of continued missed medication for 2 of 5 sampled residents (#s 62 and 115) reviewed for medications. This placed residents at risk for adverse side effects of medications and worsening medical conditions. Findings include: 1. Resident 62 was admitted to the facility in 11/2023 with diagnoses including dementia with behavioral disturbances. Resident 62's 6/5/26 care plan indicated to administer medications as ordered, and document for effectiveness or side effects. Resident 62's 5/2026 and 6/2026 signed physician's orders included the following:-Duloxetine (a depression medication) 60mg daily for depression.-Eliquis (an anticoagulant medication) 5mg two times daily for stroke.-Olanzapine (an antipsychotic medication) 5mg two times daily for agitation and hallucinations. Resident 62's 5/2026 and 6/2026 MAR revealed the following:-Duloxetine was not given on 5/4, 5/5, 5/10, 5/19, 6/18, 6/19, or 6/21.-Eliquis was not given on 5/4, 5/5, 5/10, 5/19, 6/18, 6/19, or 6/21.-Olanzapine was not given during morning medication pass on 5/4, 5/5, 5/10, 5/19, 6/18, 6/19 or 6/21. A review of Resident 62's medical record revealed no evidence the facility notified the physician of the resident's missed medications. On 6/24/26 at 9:38 AM, Staff 5 (CMA) stated it was common for Resident 62 to miss her/his morning medications, as the resident preferred to sleep in and would often refuse to get up to take her/his pills. Staff 5 stated if the resident slept through morning medication pass, she would document the information into the resident's chart and notify the nurse in charge. On 6/25/26 at 8:17 AM, Staff 10 (RN) stated she was unaware Resident 62 missed any medications. Staff 10 stated if staff were unable to administer medication to a resident for any reason, the provider would be notified. On 6/25/26 at 8:22 AM, Staff 11 (RNCM) acknowledged Resident 62's 5/2026 and 6/2026 MAR indicated the resident did not receive multiple medications on multiple days. Staff 11 could not provide any additional information related to the resident's medical provider being informed of the missed medication. On 6/26/26 at 9:21 AM, Staff 2 (Assistant DNS) confirmed Resident 62 had missed multiple medications throughout 5/2026 and 6/2026 and acknowledged the facility should have notified the provider to ensure the resident was receiving medications as ordered. 2. Resident 115 was admitted to the facility in 3/2026 with diagnoses including Parkinson's disease (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(a progressive brain disorder that occurs when nerve cells in the brain die or become impaired, resulting in a drop in dopamine) and dementia with Lewy Bodies. The 3/30/26 admission MDS revealed Resident 115 had a BIMS score of 3 indicating she/he had severe cognitive impairment. The 4/2/26 care plan revealed Resident 115 was to receive medications for Parkinson's disease as ordered and staff were to monitor, document, and report any signs or symptoms of medication side effects. The 6/8/26 physician orders revealed orders to start on 3/24/26 for carbidopa-levodopa (a medication to treat Parkinson's disease) 25-100 MG TID (8 AM, 12 PM and 8 PM) and carbidopa-levodopa extended release 50-200 MG QID (8 AM, 12 PM, 4 PM and 8 PM). Resident 115's 6/2026 MAR indicated she/he was sleeping or refused and missed carbidopa-levodopa 25-100 MG and carbidopa-levodopa extended release 50-200 MG on the following dates/times: -On 6/1/26, both doses for 8 AM administration. -On 6/2/26, both doses for 8 AM and 8 PM administration. -On 6/4/26, both doses for 8 AM administration. -On 6/5/26, both doses for 8 AM administration. -On 6/7/26, both doses for 8 AM and 12 PM administration, and 4PM administration of carbidopa-levodopa extended release 50-200 MG. -On 6/8/26, both doses for 8 AM administration. -On 6/9/26, both doses for 8 AM administration. -On 6/10/26, both doses for 8 AM and 12 PM administration. -On 6/11/26, both doses for 8 AM administration. -On 6/12/26, both doses for 8 AM administration. -On 6/13/26, both doses for 8 AM administration and 4PM administration of carbidopa-levodopa extended release 50-200 MG -On 6/14/26, both doses for 8 AM administration. -On 6/15/26, both doses for 8 AM administration. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 6/16/26, both doses for 8 AM and 12 PM administration. -On 6/18/26, both doses for 8 AM administration. -On 6/19/26, All medication administration of both doses, 8 AM, 12 PM, 4 PM, and 8 PM. -On 6/20/26, both doses for 8 AM administration. -On 6/21/26, both doses for 8 AM administration and 4PM administration of carbidopa-levodopa extended release 50-200 MG -On 6/22/26, both doses for 8 AM administration. -On 6/24/26, both doses for 8 AM, 12 PM, 8 PM administration. A review of Resident 115's medical record revealed no evidence the facility notified the physician of the continued missed doses of both carbidopa-levodopa medications until 6/24/26. A review of the 6/24/26 fax to Resident 115's physician from Staff 13 (RNCM) revealed Resident 115 missed multiple doses of carbidopa-levodopa 25-100 MG and carbidopa-levodopa extended release 50-200 MG over the last month primarily during morning medication pass at 8 AM and some at the 12 PM and 4 PM medication pass due to the resident either sleeping or was combative. Staff 13 noted that was a change from Resident 115's first couple months at the facility. On 6/25/26 Resident 115's physician responded to the fax acknowledging it. On 6/24/26 at 1:45 PM, Staff 15 (CMA) stated Resident 115 was often asleep during the 8 AM medication pass and was not woken up as the resident would try to bite her. Staff 15 stated she would reapproach the resident a second time but if the resident was still asleep, she documented in the MAR as 'sleeping' and notified the nurse of the missed dose of medication. Staff 15 stated there were no interventions in place related to the resident's continued missed doses. On 6/24/26 at 3:35 PM, Staff 16 (RN) stated when the CMA communicated to her that Resident 115 was asleep during medication pass, she would attempt to wake up the resident, but the resident often refused and continued to sleep. Staff 16 stated she then notified Staff 13 (RNCM) and it was up to Staff 13 whether to notify the provider. On 6/24/26 at 3:57 PM, Staff 17 (CMA) stated Resident 115 was often awake during the afternoon and evening medication pass and accepted her/his medications. Staff 17 stated if Resident 115 was having behaviors of agitation he would reapproach the resident and notify the nurse if Resident 115 missed any doses. On 6/25/26 at 11:54 AM, Staff 18 (CMA) stated Resident 115 had several behaviors of biting, grabbing, and kicking staff members and often was asleep during medication pass which had increased in the last month. Staff 18 stated she would reapproach the resident, but the resident often stayed asleep or refused medications. Staff 18 stated she would report to the nurse of any missed (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications. On 6/25/26 at 3:26 PM, Staff 13 (RNCM) stated over the last three to four weeks Resident 115 had an increase in behaviors and missed medications including both doses of carbidopa-levodopa. Staff 13 stated he was aware of the missed medication but did not know the frequency of missed medications until yesterday, 6/24/26 when he completed a quarterly review of Resident 115's medications. Staff 13 stated the physician would be notified every quarter or sooner, dependent on the severity of the situation. Staff 13 also stated Resident 115's physician made some medication changes related to the increase in behaviors, but it was never communicated to the physician of the multiple missed doses of carbidopa-levodopa until 6/24/26. On 6/26/26 at 11:54 AM, Staff 2 (Assistant DNS) acknowledged Resident 115 had multiple occurrences of missed medication due to the resident refused or was sleeping and no notification to the physician until 6/24/26. Staff 2 stated she would expect the nurse or the RNCM to notify the physician, especially after the Resident 115 missed the 8 AM administration of both doses of carbidopa-levodopa from 6/7/26 to 6/17/26.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure proper labeling of biologicals for 2 of 7 treatment carts and failed to ensure treatment carts were properly secured during observations. This placed residents at risk for receiving medications with reduced efficacy and unauthorized access to medications. Findings include:1. On 6/24/26 at 12:27 PM, one open Lantus insulin pen was observed in the [NAME] Unit treatment cart, it was not labeled with an open date.On 6/24/26 at 12:27 PM, Staff 3 (RN) acknowledged the insulin pen was open and not labeled with an open date.On 6/26/26 at 9:30 AM, Staff 2 (Assistant DNS) stated the expectation was for open insulin to be labeled with an open date.2. On 6/24/26 at 10:44 AM, one open Lantus insulin pen was observed in the Delta Unit treatment cart, it was not labeled with an open date.On 6/24/26 at 10:44 AM, Staff 6 (RN) acknowledged the insulin pen was open and not labeled with an open date.On 6/26/26 at 9:30 AM, Staff 2 (Assistant DNS) stated the expectation was for open insulin to be labeled with an open date.3. On 6/22/26 from 12:37 PM to 12:42 PM and from 2:59 PM to 3:01 PM, the [NAME] Unit treatment cart was observed to be unlocked and unattended. On 6/22/26 at 12:42 PM and 3:01 PM, Staff 3 (RN) acknowledged the treatment cart was left unlocked and unattended. On 6/26/26 at 9:31 AM, Staff 2 (Assistant DNS) stated the expectation was for treatment carts to be locked when unattended.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review it was determined the facility failed to ensure flu and pneumonia vaccines were provided for 3 of 5 sampled residents (#s 2, 3 and 66) reviewed for immunizations. This placed residents at risk for illness. Findings include: A review of the facility's 10/2019 Pneumococcal Vaccine policy stated residents will be offered pneumococcal vaccines within 30 days of admission to the facility unless medically contraindicated. 1. Resident 2 was admitted to the facility in 5/21/26 with diagnoses including a stroke. Resident 2's clinical record revealed she/he was eligible but not offered a pneumococcal vaccine. On 6/5/26 at 4:24 PM, Staff 2 (Assistant DNS) and Staff 12 (RN) stated eligible residents were administered pneumococcal vaccines within seven to ten days of admission to the facility. On 6/25/26 at 4:43 PM, Staff 2 and Staff 12 verified Resident 2 consented to and was eligible for a pneumococcal vaccine on 5/21/26. Staff 2 and Staff 12 stated there was no documentation in the resident's clinical record to indicate the pneumococcal vaccine was offered, administered or refused between 5/28/26 and 5/31/26 (seven to ten days after admission). 2. Resident 3 was admitted to the facility in 11/17/25 with diagnoses including congestive heart failure. Resident 3's clinical record revealed she/he was eligible but not offered a pneumococcal vaccine. On 6/5/26 at 4:24 PM, Staff 2 (Assistant DNS) and Staff 12 (RN) stated eligible residents were administered pneumococcal vaccines within seven to ten days of admission to the facility. On 6/25/26 at 4:41 PM, Staff 2 and Staff 12 verified Resident 3 consented to and was eligible for a pneumococcal vaccine on 11/17/25. Staff 2 and Staff 12 stated there was no documentation in the resident's clinical record to indicate the pneumococcal vaccine was offered, administered or refused between 11/24/25 to 11/27/25 (seven to ten days after admission). 3. A review of the facility's 10/2019 Influenza Vaccine policy stated all residents without medical contraindications were offered the influenza vaccine annually between October 1 and March 31. Resident 66 was admitted to the facility in 9/2025 with diagnoses including Alzheimer's Disease. Resident 66's clinical record revealed she/he was eligible but not offered an influenza vaccine. On 6/25/26 at 4:30 PM, Staff 2 (Assistant DNS) and Staff 12 (RN) verified Resident 66 consented to the influenza vaccine on 9/2/25. Staff 2 and Staff 12 stated there was no documentation in the resident's clinical record to indicate the influenza vaccine was offered, administered or refused between 10/1/25 and 3/31/26.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review it was determined the facility failed to offer Covid-19 vaccines for 3 of 5 sampled residents (#s 2, 3 and 155) reviewed for vaccines. This placed residents at risk for respiratory illness. Findings include: A review of the facility's 11/2021 COVID-19: Vaccination of Residents policy stated, each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated.1. Resident 2 was admitted to the facility in 5/2026, with diagnoses including a stroke. Resident 2's clinical record revealed she/he was eligible but not offered a COVID-19 vaccine. On 6/25/26 at 4:34 PM, Staff 2 (Assistant Director of Nursing) and Staff 12 (RN) verified Resident 2 consented to and was eligible for a COVID-19 vaccine on 5/21/26. Staff 2 and Staff 12 stated there was no documentation in the resident's clinical record to indicate the COVID-19 vaccine was offered, administered or refused. 2. Resident 3 was admitted to the facility in 11/2025, with diagnoses including congestive heart failure. Resident 3's clinical record revealed she/he was eligible but not offered a COVID-19 vaccine. On 6/25/26 at 4:30 PM, Staff 2 (Assistant DNS) and Staff 12 (RN) verified Resident 3 consented to and was eligible for a COVID-19 vaccine on 11/17/25. Staff 2 and Staff 12 stated there was no documentation in the resident's clinical record to indicate the COVID-19 vaccine was offered, administered or refused.3. Resident 155 was admitted to the facility in 3/2026 with diagnoses including Parkinson's Disease. Resident 155's clinical record revealed she/he was eligible but not offered a COVID-19 vaccine. On 6/25/26 at 4:37 PM, Staff 2 (Assistant DNS) and Staff 12 (RN) verified Resident 155 consented to and was eligible for a COVID-19 vaccine on 3/20/26. Staff 2 and Staff 12 stated there was no documentation in the resident's clinical record to indicate the COVID-19 vaccine was offered, administered or refused.		