STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145476	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon Living and Rehabilitation Center	811 South 10th Street Oregon, IL 61061

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 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** 38488 Based on observation, interview, and record review the facility failed to supervise a resident with dementia in a manner to prevent choking on a non-food item for 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 4. The findings include: R1's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include dementia without behavioral disturbance, vascular dementia, severe, with other behavioral disturbance, falls, age-related osteoporosis, mood disorder, anxiety disorder, and insomnia. R1's facility assessment dated [DATE] showed she has severe cognitive impairment, exhibits frequent wandering behaviors, and requires supervision with ambulation. R1's care plan initiated 5/9/24 showed, [R1] has impaired cognition due to diagnoses dementia and will place non-food items in her mouth and attempt to swallow Staff will monitor resident during mealtimes. When [R1] leaves the table, staff will redirect [R1] to the table or monitor her in the common area . R1's care plan initiated 3/6/23 showed, [R1] has impaired cognitive function related to dementia . (3/6/23) Cue, reorient, and supervise as needed . (5/10/24) Staff will redirect [R1] if she attempts to eat inedible objects . The facility's daily nursing staff assignment sheet for 5/8/24 was reviewed and showed at the time of R1's incident the staff on the unit consisted of V4 LPN (Licensed Practical Nurse), V6 CNA (Certified Nursing Assistant), V7 CNA, V8 CNA, and V9 CNA. The Activity Aide schedule was reviewed and showed no activity aide was on the unit on 5/8/24 from 4PM-8PM. The facility's May 2024 Memory Care Unit activity calendar showed an activity on 5/7/24 at 2:30 PM for Mama Day Flower Arranging. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145476	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon Living and Rehabilitation Center	811 South 10th Street Oregon, IL 61061

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's 5/8/24 Nursing Note entered at 6:39 PM showed, Approximately 6:05 PM, CNAs (Certified Nursing Assistants) called this nurse to dining room due to resident showing universal sign for choking. CNA had already initiated the Heimlich maneuver. During the Heimlich, resident's lips did begin to turn blue. After approximately 1 minute, airway was cleared and resident began to cough and eventually was able to speak. 911 had already been called during episode so they arrived approximately 6:13 PM and checked resident over. VS (vital signs) were within normal limits and resident was able to speak clearly. POA (Power of Attorney) was notified and his wishes were to keep resident at facility and monitor as long as she seemed to be doing ok . On 5/10/24 at 3:30 PM, V7 CNA (Certified Nursing Assistant) said she was working the night that R1 choked. V7 said, I was passing trays and setting them up in the dining room when I heard [V8] say R1 was choking. I went and got the nurse [V4] and had her come into the dining room . It was floral foam she was choking on. I saw it all over the table. In the dining room at the time was me, an orientee, and another CNA. There may have been another CNA in there (V6) but I don't know for sure. [R1] likes to get into other peoples things and she is constantly in other rooms taking things. It was odd for her to put things in her mouth though. She goes into resident's rooms and brings things out. She choked on the foam from a Mother's Day activity. Several of the residents had them in their rooms and a lot of the foam was all torn up and found on their floor. The activity was a Mother's Day bouquet. The planter part was a paper (disposable) cup, the foam was inside, and then they stuck a flower into the foam. After this happened, we threw the flowers away and kept a closer eye on [R1]. On 5/10/24 at 2:45 PM, V8 CNA said, We had just gotten in on shift. I was checking trays when [R1] came up coughing. She was taking okay but it was weird so I followed her into the dining room. She coughed up a green piece of foam then she stopped coughing and breathing. To my knowledge she was in the lobby area. She kind of goes everywhere. She spit out a wad of foam about 1/2 golf ball size. They had done activities recently making little paper cups with a small chunk of foam in it for a flower. After the incident as I was doing lay down with the residents I found chunks of foam throughout the rooms on the floor so I think she may have been in the rooms. She is very in and out of other resident's rooms . After that we obviously kept a better on her and we threw away all the arrangements. On 5/10/24 at 10:14 AM, V9 CNA said, It was right around dinner. I was in the dining room feeding two residents when [R1] walked into the dining room. Her face was red, she was coughing and choking. The girl I was working with decided to start the Heimlich Maneuver. Once they did the Heimlich there was green stuff that came out. It was like foam that you put fake flowers in. On 5/10/24 at 10:35 AM, V6 CNA said, She walked into the dining room. We were in the middle of feeding residents. She walked in and she was coughing. Then she went silent. Then (V8) did less than a minute of the Heimlich Maneuver and we got it out. It was a light green and it was in very little pieces. It is hard to say where she got it. During dinner she will take things off peoples trays, go into other resident's rooms and collect things, we find her in the hall and take the things back. Otherwise she will drop them off at the nurse's station or leave the items in other resident's rooms. V6 said she was in the dining room along with V7, V8, and V9. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145476	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon Living and Rehabilitation Center	811 South 10th Street Oregon, IL 61061

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/10/24 at 10:27 AM, V4 LPN said, When (R1) choked I was in another resident's room at the time. The CNA called for help. I went right to the dining room and there was a CNA doing the Heimlich Maneuver. It was found to be foam from fake flowers. We had called 911 so when they got there she was sitting down and her vital signs were fine [V7] called for me and [V8] was doing the Heimlich. We found green foam in her pocket. We did a sweep of the whole unit and removed any fake flowers that had the foam in them. We were unable to determine where the foam came from. We monitored her after that and kept a close eye on her . On 5/10/24 at 1:25 PM, V2 DON (Director of Nursing) said, . She choked on a non-food item. A little foam piece like the green foam from a plant arrangement. Activities had recently put flowers in resident's rooms for Mother's Day. Intervention-wise we did a sweep of rooms to ensure all the foam was removed and discarded outside of the unit and make sure snacks are available to help avoid her eating non-food items. The facility's with review date of 6/24/21 showed, Safety and Supervision of Residents; Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Resident-Oriented Approach to Safety, 1. Our resident-oriented approach to safety addresses safety and accident hazards for individual residents . The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition . Residents Risks and Environmental Hazards, 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: . e. Unsafe Wandering .