| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145476 | A. Building<br>B. Wing | 09/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oregon Living and Rehabilitation Center | 811 South 10th Street<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on observation, interview, and record review the facility failed to report an allegation of misappropriation of resident property to the local health department and failed to report two allegations of misappropriation of resident property to the local authorities. This applies to 2 of 3 residents (R54 and R61) in the sample of 36. The findings include:1. R61's admission Record (Face Sheet) showed an admission date of 4/7/25.R61's misappropriation investigation, dated 8/27/25, showed Administrator (V1) was notified by [V7] Sister in law of [R61] that [R61] has had some money missing. [V7] stated that she gave [R61] 180 dollars in 20.00 bills on Saturday afternoon (8/23/25). This writer spoke to [R61] who stated that she received the money on Saturday afternoon and placed it in her purse that she keeps around her neck at all times and only removes it when she is sleeping. On Monday afternoon [R61] checked her purse and saw the money in her purse. On Tuesday afternoon it was gone. This writer searched for the resident's room and purse with resident present. This writer reviewed camera footage from 2000 (8:00 PM) On Monday to the morning hours of Tuesday. I have reviewed cameras and the staff who enter are not in room for any length of time to rummage a drawer. It is quick in and out. This writer can see staff members passing linens and doing rounds together. The cameras reveal that for care and longer visits they are inside the room in pairs. [R61] would have been woken up to get the care provided. This writer spoke with staff members that were assigned to work that shift and confirmed that they worked in pairs during rounds. This writer spoke with [R61] and informed her of what the camera showed. This writer asked [R61] how she wanted to proceed. [R61] stated that she wanted to move on from this and did not blame the facility or anyone in the facility. This writer spoke with [V7] who brought in the money. This writer informed [V7] of what was shown on the cameras and informed [V7] that [R6] just wanted to move on from this. This writer asked [V7] how she wanted to proceed with this. [V7] agreed that she wanted to move on from this and stated that she had a feeling that the money would show up somewhere and that perhaps it was misplaced.On 9/9/25 at 10:41 AM, R61 stated, .someone was taking items. R61 stated .I had $180 go missing. I noticed it about two weeks ago that the money went missing. R61 stated V7 had brought her money over the weekend. R61 stated she knew she had the money because she had checked her wallet on Monday (8/25/25). R61 stated she had checked her wallet because she was going to have someone do shopping for her and she wanted to verify the money was available. R61 stated she went to get the money on Tuesday (8/26/25) from her purse for her personal shopper and the $180 was not in her purse. R61 said, .They asked me what I wanted to do about it and I said I didn't want to do make a fuss, then [R54] said at a church meeting that she had money go missing as well. On 09/10/2025 at 9:14 AM, V7 R61's Sister-in-Law stated R61 had wanted cash for shopping and states to the best of my recollection she put the money in her billfold. V7 stated she then received a phone call from R61 that the money was missing, she needed more cash, and she didn't want to do anything about the missing money. V7 said, I said, [R61] are you sure it was in there, and she said no it's not in there, and that is when I got concerned but she was adamant it (money) was in there (her black purse) and she is very sharp about that stuff. V7 stated she asked R61 if she had ever left her purse unattended and R61 replied that she had left it unattended for a<br>(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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145476 | A. Building<br>B. Wing | 09/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oregon Living and Rehabilitation Center | 811 South 10th Street<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | short time while she was at an activity. V7 said, .[R61] told me someone is a little light fingered and I asked if she reported it, and she said no so I said I would call and report it. Knowing [R61] as I do, if she saw that money on Monday, she would not have misplaced it. She keeps that purse with her all the time. There would have been no reason for her to take out that money; that would be out of character for her. She keeps that black purse with her all the time and the one time she didn't have it with her.She said she had left it in her room for bingo, I was surprised she had done that because normally she takes it with her everywhere she goes. When I reported it, I thought maybe she set it somewhere else, maybe it fell out of her purse. V7 said she never spoke to the police about this incident. On 09/10/2025 at 9:46 AM, R61 was asked, What do you think happened to the money? R61 replied, I did not lose the money and they couldn't find it, so that tells you what I think happened to the money. I think someone took the money based on other residents that have had issues, but I don't want to point the finger. I kept the money in my black purse. On 9/10/25 at 9:46 AM, R61 had her purse on her overbed table. R61 was supine in bed watching a video on her phone. 09/10/2025 at 11:17 AM, V8 Certified Nursing Assistant (CNA) stated, she has worked at the facility since 2018 and she knows R61. V8 said, R61 is alert and oriented and she does not have any behaviors. V8 said, R61 takes her black purse with her everywhere she goes. On 9/10/2025 at 12:07 PM, V9 Licensed Practical Nurse (LPN) stated R61 is alert and oriented and she does not have any behaviors. V9 stated she was aware of R61's missing money and V9 said that is the only allegation R61 has made regarding missing personal property. V9 said R61 carries her black purse with her everywhere she goes. On 09/10/2025 at 12:56 PM V1 Administrator stated she has been the facility's administrator for just over a year and she is the abuse coordinator. V1 said V7 called her and told her that R61 was missing $180. V1 said, The sister-in-law said the money was brought in over the weekend. [V7] said she had the money on Monday and then it was gone on Tuesday. We started checking the cameras from Monday to Tuesday, but nothing could be determined from that. Then [V7] said she probably misplaced it and said she didn't want to proceed with it. V1 said R61's missing money was not reported to the local health department or the local authorities. V1 said the reports were not made because [R61] was not reported to [the local health department] because the family and [R61] wanted nothing to be done with it and they really thought the money would be found. V1 said R61's money has not been found (more than two weeks later.) V1 was asked what allegations of abuse and misappropriation should be reported to the local health department and the local authorities, V1 stated she would have to return with that answer. V1 stated, I would call the police, if there is immediate danger to the resident. I've never had to call the police for an allegation of abuse. I've never heard that any reasonable suspicion of a crime has to be reported to the police. The facility's Abuse Prevention Program (reviewed 11/15/24) showed, .Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent.Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.Initial reporting of allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made , the administrator, or designee, shall notify Department of Public Health's regional office immediately by telephone or fax.This report shall be made immediately. Informing local law enforcement. The facility shall also contact local law enforcement authorities if the following situations.When there is reasonable suspicion that a crime has been committed in the facility by a person other than a resident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145476 | A. Building<br>B. Wing | 09/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oregon Living and Rehabilitation Center | 811 South 10th Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure hot liquids were served at a safe temperature for all residents residing in the facility, failed to ensure a resident was transferred with a gait belt for 1 resident (R41). The findings include:1) The facility's roster provided to surveyors on 9/9/25 showed 70 residents residing in the building.On 9/9/25 at 12:20PM, V3 (Dietary Manager) showed surveyor the facility coffee and hot water machine. V3 stated, The machine is set to 205 degrees Fahrenheit. That is set by the company that services it.On 9/9/25 at 12:26PM, R34,R45,R54, and R61 all had hot coffee served to them. All residents stated the coffee was too hot to drink and it needed to cool awhile before drinking it. The coffee was observed to be steaming in all 4 resident's mugs.On 9/10/2025 at 7:58AM, V3 obtained the temperatures of the hot coffee and hot water that was poured into the carafes and being taken out to the dining area. The hot coffee temperature was 173 degrees Fahrenheit, and the hot water was 154 degrees Fahrenheit. V3 stated, We don't have a process for hot liquids it just goes right from the machine that is always set at 205 degrees Fahrenheit and it goes straight to the carafe and out to the residents.On 9/10/25 at 8:08AM, The first resident was being served hot coffee. The temperature of the hot coffee was 170 degrees Fahrenheit, and the hot water was 138 degrees Fahrenheit. On 9/10/25 at 1:07PM, V2 (Director of Nursing) stated, I'm not sure if we do hot liquid assessments or what the safe temperature for hot liquids would be. You want it hot enough that it's enjoyable but not hot enough to burn them if they spill it.On 9/10/25 at 1:32PM, V5 (Regional Director of Operations) stated, We have never done hot liquid assessments for our residents. I'm not sure where we would even document that in our system. Our policy for serving hot liquids is 180 degrees or below are safe to serve to residents.The facility's policy titled, Safety of Hot Liquids dated 3/21/25 showed, Residents will be evaluated for safety concerns and potential for injury from hot liquids upon admission, readmission and on change in condition. Appropriate precautions will be implemented to maximize choice of beverages while minimizing the potential for injury .4. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include maintaining hot liquids serving temperature of not more than 180 degrees Fahrenheit .2) R41's electronic face sheet printed on 9/11/25 showed R41 has diagnoses including but not limited to history of falls, type 2 diabetes, chronic kidney disease, depression, and muscle weakness.R41's facility assessment dated [DATE] showed R41 has no cognitive impairment and requires substantial/maximal assist for ambulation.R41's physician's orders dated 5/14/25 showed, 1 assist, gait belt for all transfers.R41's fall risk assessment dated [DATE] showed R41 is a high fall risk.R41's care plan dated 6/3/25 showed, (R41) has limited physical mobility related to weakness, syncope, and assistance required for ambulation .(R41) is able to ambulate with restorative aide, gait belt, and her four wheeled walker.R41's nursing progress notes dated 8/15/25 showed, Patient was ambulating with her walker and tripped and fell. She bumped her back against the walker .Patient states her back is tender where she bumped it IDT (Interdisciplinary Team) reviewed the resident's fall. Root cause of fall determined to be unsteady gait/ambulation; resident being assisted to the toilet without a gait belt when ambulating .On 9/9/2025 at 1:27PM-, R41 stated, It was the middle of the night, and I had a girl come in and help me to the bathroom because I can't go on my own. I lost my balance and I fell towards my back and side area. I was walking with the walker because therapy said I could walk that far with the walker with help. She did not have the belt around me. I don't remember what I was wearing on my feet. I was either barefoot or had the slip-on shoes on. It all happened so fast. I fractured a few ribs. Now that I fell, they make sure they put the belt around me, and I continue to ask for help to get up. Before I came here, I was falling pretty much every week, if not more.The facility Incident Report Investigation dated 8/16/25 showed, On 08/16/25 at 5:35PM, (Local Imaging<br>(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<br>B. Wing | 09/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oregon Living and Rehabilitation Center | 811 South 10th Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Company) called and faxed results of x-rays reveals subacute fractures of the lateral right 5th,6th and 7th ribs. Subacute is in healing stages, most likely fractures are related to falls prior to admission. Physician was called and faxed results.On 9/10/25 at 11:17AM, V6 (Certified Nursing Assistant) stated, I was transferring (R41) to the bathroom in the night, and she used her walker. I did not have a gait belt on her. She started to fall sideways, and I couldn't grab onto her fast enough and she fell on her bottom and then fell over to her side. I know I should have had the belt on her, but she is usually pretty steady so I didn't think it would be an issue.On 9/10/25 at 1:07PM, V2 (Director of Nursing) stated, Staff should have used a gait belt when transferring (R41) to help keep the resident steady and if they are going to fall then you have something to grab onto to either lower them safely or prevent the fall.The facility's policy titled, Safe Lifting & Movement of Residents dated 3/21/25 showed, In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents .4. Gait belts shall be used on residents unless residents are independent with ambulation, or supervision only, or contraindicated in the resident's care plan. |