

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER Oregon Living and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>(continued on next page)</p>

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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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure that food was prepared appropriately to meet the needs of a resident with chewing difficulties for 1 of 3 residents (R1) reviewed for therapeutic diets in the sample size of 3. This failure resulted in R1 receiving diced ham instead of ground ham as recommended for a mechanical soft diet per facility's dietary spreadsheet recommendations and led to R1 having a choking episode. The findings include: R1's face sheet documented last admission date of 03/27/2025 with a past medical history not limited to vascular parkinsonism, dementia, anxiety, depression, dysphagia, and cognitive communication deficit. Review of R1's electronic medical records showed a speech therapy order dated 06/09/2025 for swallowing therapy related to treatment of swallowing dysfunction and treatment of oral function for feeding. R1's therapy/nursing communication form dated 07/01/2025 documented to continue with mechanical soft diet consistency. Review of nutritional care form dated 09/11/2025 completed by V9 (Registered Dietician) indicated that R1 has chewing issues. Review of R1's incident report submitted to the Department of Public Health (IDPH) indicated that on 11/03/2025 at 05:45 PM (1745), R1 was in dining room on same date at dinner time and served a diet as ordered. R1 had just started to eat when the V5 (Certified Nursing Assistant) heard R1 start gurgling. V5 observed R1's lips turn blue, and resident was unable to cough up food. V5 asked R1 if she was choking, and she nodded yes. V5 attempted to give her the Heimlich while another aide went to get the nurse (V4-Licensed Practical Nurse). V5 had already given two abdominal thrusts and noted resident coughed up food. R1 said she was okay. When V4 arrived, R1 was observed sitting in the dining room. R1 stated, I couldn't get certain pieces down. R1 coughed up visible food/liquids after incident. Physician was notified and orders were received to downgrade R1's diet to pureed, and for speech therapy to evaluate and treat. R1's progress note dated 11/04/2025 at 10:41 PM (22:41) indicated that certified nursing assistant (CNA) reported R1 was gurgling, observed her lips turned blue, and resident was unable to cough up food. CNA initiated the Heimlich maneuver and nurse was immediately notified. When nurse (V4) arrived in the dining room, R1 was observed sitting in the dining room eating a cookie. Resident stated, I couldn't get certain pieces down. CNA had initiated the Heimlich maneuver and after approximately one minute, airway was cleared, and resident began to cough and eventually was able to speak. CNA (V5) stated she was in the dining room, assisting residents with feeding when she heard a gurgling sound behind her. CNA turned around and resident (R1) was blue. CNA asked R1 if she was choking, and she nodded yes. R1 could not cough up the food, so CNA patted her on the back and lifted her arm with no response. CNA had to give the Heimlich Maneuver and after giving two abdominal thrusts, the food came out and R1 was okay. R1's progress note dated 11/04/2025 at 10:45 PM (22:45) indicated R1's diet was downgraded to pureed until further notice. R1's speech therapy (ST) evaluation and plan of treatment dated 11/07/2025 indicated that R1 was being seen due to a choking incident on 11/04/2025 that required abdominal thrusts to expel food. Prior ST intervention in June 2025 due to choking incident. Downgraded to puree solids from regular solids at that time, eventually upgraded to mechanical soft solids following ST intervention. Patient presents at assessment with mild oral and suspect mild pharyngeal dysphagia (swallowing disorder) with increased risk for aspiration/choking due to cognitive impairment. Continue puree solids and thin liquids, crush medications in applesauce. Continue supervision during oral (PO) intake due to multiple choking events. On 11/12/2025 at 09:45 AM, V1 (Administrator) stated that R1's incident date was incorrectly submitted to IDPH, and the actual incident date was 11/04/2025. R1's active orders as of 11/12/2025 showed an order for pureed diet with start date of 11/04/2025. Review of discontinued orders showed: general diet, mechanical soft texture, regular consistency that was discontinued on 11/4/2025. R1's care plan with print date of 11/12/2025 reads in part: swallowing problem related to coughing or choking during meals or swallowing med, initiated 11/05/2025. Interventions included: follow prescribed diet, monitor for signs of dysphagia, refer to speech therapist, resident to eat only with supervision, and diet changed to puree until speech therapy evaluation for safety. On 11/12/2025 at 10:17 AM, observed R1 lying in bed. R1 said she did not recall anything about the choking incident. On 11/12/2025 at 11:50 AM, V5 (CNA) said was sitting in the dining room assisting another resident with meal and R1 was seated behind her. V5 then said she heard a gurgling sound then turned around and asked R1 if she was choking; R1 nodded her head up and down. V5 added that R1's lips were dark blue and her whole face was turning blue from a lack of oxygen. V5 patted R1 on the back and lifted her arms, but nothing happened so V5 went behind R1 and gave her two upward abdominal thrusts. V5 said that R1 coughed food that looked</p>		