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	01/22/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement interventions to prevent a confused resident (R1) from wandering into another resident's (R2) room. This failure resulted in both residents being found in bed together and R2 was inappropriately exposed. This failure affected one (R1) of three residents reviewed for quality of care in the sample of 3.The findings include:1. Review of facility's final incident report reads in part: on 01/16/2026, staff entered a resident room and observed a fully dressed female resident lying in bed with a male resident. The male resident was unclothed. The male resident's hands were observed resting on the bed, and the female resident's hands were positioned at her sides. No movement or sexual activity was observed at the time of discovery. Both residents appeared calm and exhibited no signs of distress. Staff immediately separated the residents.A post-incident body assessment of the female resident revealed clothing intact with incontinence brief in place. No injuries, bruising, or signs of trauma were noted. The male resident also exhibited no injuries. Both residents were interviewed and were unable to recall how or why they were in bed together or whether any interaction had occurred. The staff witness reported that no motion, refusals, verbalizations, or indications of negative or inappropriate behavior were observed. The male resident has no prior history of sexually inappropriate behavior and is typically quiet and remains in his room.The investigation was conducted in accordance with facility policy and federal regulations. Based on the findings, the allegation of sexual abuse is determined to be unsubstantiated. No further behaviors or concerns have been observed.R1's face sheet documented an admission date of 02/28/2023 with a past medical history not limited to: Alzheimer's Disease, need for assistance with personal care, mood [affective] disorder, psychosis, anxiety disorder and Dementia. R1's abuse/neglect assessment dated [DATE] documented R1 scored 6 that indicates she is at high risk for abuse/neglect (high: 6-7 intense: 8-12).R1's wandering/elopement assessment dated [DATE] documented resident is at high risk for wandering/elopement due to diagnosis of Dementia/Alzheimer's/confusion, independently mobile, paces/wanders, and history of elopement/wandering. R1's Minimum Data Set (MDS) Section C Brief Interview for Mental Status (BIMS) Evaluation (page 11 of 59) dated 01/09/2026 indicated R1 has severe cognitive impairment.R1's care plan last reviewed 01/16/2026 reads in part: has diagnosis of dementia and utilizes staff assistance with activities to ensure highest level of psycho-social functioning. Interventions included: allow her to socialize with others in common areas and encourage R1 to participate in group programs. R1's care plan also documented she is an elopement risk/wanderer related to impaired safety awareness, dementia, and Alzheimer's disease. Interventions included: distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, has a baby and enjoys caring for it, provide structured activities such as toileting, walking inside, and reorientation strategies including signs, pictures and memory boxes.R1's progress note dated 01/16/2026 at 09: 12 PM (21:02) documented that R1 was in another male resident bed (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fully dressed.On 01/22/2026 at 10:40 AM, observed R1 seated at a table in the common area on 200 unit near nurse's station with other residents, engaging in a puzzle activity. At 10:52 AM, attempted to interview R1 in her room. She was alert to self and unable to recall any details of incident in R2's room.2. R2's face sheet documented an admission date of 06/16/2025 with a past medical history not limited to: Dementia, mood [affective] disorder, anxiety, alcohol abuse, and insomnia. R2's MDS Section C Brief Interview for Mental Status (BIMS) Evaluation (page 10 of 54) dated 12/08/2025 documented score of 13/15 and indicated an intact cognitive response. R2's progress note dated 01/16/2026 at 09:00 PM (21:00) documented that R2 was in his bed with a fully dressed female (R1) resident. Residents were separated. Neither resident was upset or recalled the incident. R1 was unbothered.On 01/22/2026 at 10:34 AM, R2 was observed sitting in his recliner chair in his room watching television. R2 said last week after supper, while in his room getting ready for bed, a woman (R1) wandered into his room and sat down on his bed. R2 then said he told her to leave several times, but she wouldn't get off his bed or leave his room. R2 indicated that the woman (R2) was fully dressed, and he was wearing a t-shirt and underwear. R2 said he was standing in front of her when a bunch of staff came in and started hollering and took her out of my room then he went to bed. R2 said he never laid in bed with the woman (R1) or did anything with her. On 01/22/2026 at 01:28 PM, V1 (Administrator) said she talked with V7 (Activity Aide) who said R1 was last seen on the couch in the 200 unit common area by the nurse's station around 6:30 PM. V7 did not see R1 after that. V1 added that residents had just finished having dinner and staff were getting other residents ready for bed during that time. On 01/22/2026 at 02:55 PM, V6 (Certified Nursing Assistant) said R1 wanders and goes into other resident's beds, is a typical behavior of hers. V6 added that R1 wanders often, and staff can usually redirect her. V6 then said she last saw R1 around 06:15 PM in the larger dining room on the 200 unit and last saw R2 in the smaller dining room on the unit around 06:30 PM. V6 also said both residents can ambulate per self. V6 said R1 most likely left her dining room and was either looking for a bathroom or her room and when someone sees her, she is redirected. V6 added that everyone must have been busy that no one saw her walking down the hall and said there is usually an activity aide in the common area but if she was on break or in the bathroom or assisting another resident, she didn't see R1 wander down the hall. On 01/22/2026 at 03:30 PM, V7 (Activity Aide) said that she was works on the 200 unit and is supposed to stay in the common room at all times and does 1:1 activities with the residents. V7 then said on the night of 01/16/2026, a staff member walked R1 into the common room after dinner around 06:30 PM and sat her down on the couch. V7 said she did not engage in any 1:1 activity with R1 because she was watching television. V7 then said she heard some commotion going on down the hall about 7:00 or 07:30 PM and noticed that R1 was no longer in the common area at that time. V7 added that she did not know what time R1 had left the common room and did not recall whether she (V7) had left the common area. On 01/22/2026 at 04:31 PM, V1 (Administrator) said residents are encouraged to partake in activities to prevent wandering along with individualized interventions that are care planned for the resident.On 01/22/2026 at 04:34 PM, V2 (Regional Director of Operations), said an activity aide is assigned to the dementia unit from 4:00 to 8:00 PM. The aide is to stay in the common area and keep residents engaged in activities until they are put to bed.Resident Wandering and Elopement last reviewed 03/21/2025 reads in part: the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement.Residents with dementia who wander may pose a risk to themselves due to the inability to identify the hazards.MDS will be completed as well as care plan with individualized interventions.