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	04/02/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent the diversion of a resident's controlled substance. This applies to 1 of 3 residents (R1) reviewed for misappropriation in the sample of 3. The findings include:R1's admission Record (Face Sheet) showed R1 was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia, anxiety, and depression. R1's 2/26/26 Quarterly Minimum Data Set (MDS) showed she was unable to respond to questions such as her ethnicity and race, and she was unable to complete the Brief Interview for Mental Status test. R1's MDS showed she had short and long-term memory problems. The MDS showed she had not received as needed pain medication in the previous 5 days and she had no signs or symptoms of pain in the previous 5 days. R1's February 2026 Medication Administration Record (MAR) showed, Screen for pain every shift (three times a day). The entire month of February showed staff documented 0 for this pain assessment on a scale of 0 to 10. R1's MAR showed an order for hydrocodone-acetaminophen 5-325 milligram (mg) (a combination narcotic and over-the-counter pain medication) to be given every 12 hours as needed for pain. R1's MAR showed only one documented administration of hydrocodone-acetaminophen, which was on 2/14/26 at 2:34 PM. R1's MAR showed this was her only order for hydrocodone-acetaminophen, which was started on 11/11/25 and was discontinued on 3/4/26. R1's March 2026 MAR showed no documented administrations of her as needed hydrocodone-acetaminophen medication prior to it discontinuing on 3/4/26. R1's March MAR showed the as needed hydrocodone-acetaminophen order was transitioned to a scheduled order of hydrocodone-acetaminophen 5-325 mg, which was to be given twice daily starting on 3/4/26. R1's MAR showed her first scheduled dose of hydrocodone-acetaminophen was not administered until 6:00 PM on 3/6/26 for a pain rating of 0 out of 10. R1's pain assessment from 3/1/26 through 3/6/26, completed every shift, showed a documented pain of 0 out of 10. The facility's Investigation Report for 3/4/26 showed, On March 4, 2026, this writer (V1 Administrator) was informed of a potential misappropriation of a resident's narcotic medication. The concern was raised following the identification of a discrepancy in narcotic count records . A potential discrepancy (gap) was identified between narcotic counts and documented administration. A prn (As Needed) medication was delivered in months prior but no sheet or card could be located.It was determined that the discrepancy could have resulted from documentation errors, specifically: 1) Failure to sign out PRN narcotic medications at the time of administration. 2) Incomplete or missing entries on narcotic log sheets. 3) Improper paper handling.The investigation concluded that the initial concern of narcotic misappropriation was unsubstantiated. The discrepancy identified could be attributable to documentation omissions rather than diversion. On 4/2/26 at 8:15 AM, all completed or wasted controlled substance counts sheets for all residents in the facility were requested dating back to 1/1/26. On 4/2/26 at 9:56 AM, V2 (Director of Nursing-DON) stated the missing hydrocodone-acetaminophen was R1's. On 4/2/26 at 9:48 AM, V2 provided two binders with the residents' controlled substance count sheets in alphabetical order. The binder showed R1's only hydrocodone-acetaminophen controlled substance count sheets began on 3/6/26. The hydrocodone-acetaminophen count sheet starting on 3/6/26 showed it had been delivered that day. It was requested that V2 verify there were no further missing controlled substance (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	count sheets prior to 3/6/26. On 4/2/26 at 10:22 AM, a record of all controlled substances delivered to the facility by the pharmacy was requested. The facility provided a sheet titled Daily Narcotic Usage. The sheet showed 60 tablets of hydrocodone-acetaminophen were delivered on 2/18/26 for R1. (At twice-daily administration, if given the maximum frequency, this delivery should have lasted 30 days; approximately March 20, 2026.) The facility's North Unit (R1's unit) Controlled Substance Accountability Record Card-Sheet Count (CCS). The CCS is a count/record of the controlled substance cards, not the individual tablets. The facility also counted the controlled substance count sheets as well as the medication cards. The facility was unable to produce the CCS for R1's medication cart for the period when R1's hydrocodone-acetaminophen was delivered on 2/18/26 or the days immediately following. The last CCS was on 2/18/26 at 10:00 AM (medications are typically delivered in the evening) and the next sheet starts on 2/20/26 at 6:00 PM. On 4/2/26 at 11:04 AM, V2 (DON) stated V4 (Licensed Practical Nurse-LPN) disputed her initials on the 2/20/26 CCS at 6:00 PM. On 4/2/26 at 12:04 PM, V4 (LPN) stated she had been shown the CCS sheet for 2/20/26 by V1 (Administrator) and she told V1 they were not her initials. V4 stated she left work around 2:00 PM, not 6:00 PM. V4 stated she was furious that someone forged her initials on the CCS. (The CCS entry for 2/20/26 was documented as being done by V4 at 6:00 PM) V4 stated the event that triggered the investigation was when R1's hydrocodone-acetaminophen transitioned to scheduled versus as needed. V4 stated she worked the day shift on 3/4/26, the day R1's scheduled hydrocodone-acetaminophen began. V4 stated the off-going night nurse reported she had requested a refill of R1's hydrocodone-acetaminophen. V4 stated she also called the pharmacy first thing in the morning, and she was eventually told R1's hydrocodone-acetaminophen could not be refilled because it was too soon. V4 stated R1 was non-verbal due to her dementia, and she rarely witnessed R1 showing and signs or symptoms of pain. V4 stated she could not recall giving R1 as needed hydrocodone-acetaminophen. V4 stated she was the nurse on 2/18/26 who received R1's hydrocodone-acetaminophen. V4 stated she signed and filled out the hydrocodone-acetaminophen controlled substance count sheets; she then filled out the CCS as having received two new cards; and then put the cards in the medication cart lock box. On 4/2/26 at 12:53 PM, V3 (LPN) stated she has taken care of R1 for a while. V3 stated she had never needed to give R1 as needed hydrocodone-acetaminophen for pain. V3 stated she was surprised when the order was changed from as needed to schedule because R1 showed no signs or symptoms of pain. On 4/2/26 at 1:27 PM, V6 (Certified Nursing Assistant-CNA) stated she knows R1 well. V6 stated the last time she recalls R1 having pain was a few months ago but otherwise never really saw her having pain over the past few months. No wincing or anything. On 4/2/26 at 2:12 PM, V7 (CNA) stated she knows R1 and she cannot recall R1 having pain in recent memory. On 4/2/26 at 2:12 PM V2 (DON) stated the start of the investigation was when it had been reported R1's hydrocodone-acetaminophen could not be filled because it was too soon. V2 stated she has been unable to locate R1's February hydrocodone-acetaminophen count sheets or the CCS for R1's hydrocodone-acetaminophen delivery. V2 stated these were searched for as a part of the facility's investigation. V2 stated the medications belong to the residents and the facility is responsible for them. V2 stated controlled substances, like hydrocodone-acetaminophen, are required to be counted, cards counted, and they need to be double locked due to the risk of diversion/misappropriation. V2 stated these controlled substances have a high risk for addiction and they have street value. V2 stated the facility could not account for R1's hydrocodone-acetaminophen. V2 stated there is no record the medications were destroyed. V2 stated the controlled substance counts sheets should be the most accurate reflection of a resident's controlled substances (when they were given, how much was administered, and the remaining amount) because the counts are verified at the beginning and end of every shift. On 4/2/26 at 3:07 PM, V1 (Administrator) stated the facility arrived at the determination R1's hydrocodone-acetaminophen was not diverted because no other resident's medications could be identified as missing, no nurse could be identified, it's possible it was a documentation issue, and (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's pain control schedule was not disrupted. V1 was asked, given the following information, how the facility could state this was possibly a documentation issue; there are two missing count sheets, a missing CCS for the time period in question, R1 had nearly no documented pain in February 2026 necessitating the need for hydrocodone-acetaminophen, R1's 2/18/26 hydrocodone-acetaminophen should have lasted 30 days, and the potential forgery of V4's initials on the CCS; V1 replied, We came to the conclusion based on no definitive evidence of diversion. We couldn't identify one nurse, so we looked at mishandling of the sheets, but I do see your thought process. The facility's Abuse Prevention Program (policy, reviewed 9/18/25) 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. The policy showed all employees are trained on what constitutes abuse, neglect, exploitation, and misappropriation of resident property.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to report an allegation of misappropriation of resident property to the State Agency as well as local law enforcement. This applies to 1 of 3 residents (R1) reviewed for misappropriation in the sample of 3. The findings include:The facility's Investigation Report for 3/4/26 showed, On March 4, 2026, this writer (V1 Administrator) was informed of a potential misappropriation of a resident's narcotic medication. The concern was raised following the identification of a discrepancy in narcotic count records . A potential discrepancy (gap) was identified between narcotic counts and documented administration. A prn (As Needed) medication was delivered in months prior but no sheet or card could be located.It was determined that the discrepancy could have resulted from documentation errors, specifically: 1) Failure to sign out PRN narcotic medications at the time of administration. 2) Incomplete or missing entries on narcotic log sheets. 3) Improper paper handling.The investigation concluded that the initial concern of narcotic misappropriation was unsubstantiated. The discrepancy identified could be attributable to documentation omissions rather than diversion. R1's February 2026 Medication Administration Record (MAR) showed, Screen for pain every shift (three times a day). The entire month of February showed staff documented 0 for this pain assessment on a scale of 0 to 10. R1's MAR showed an order for hydrocodone-acetaminophen 5-325 milligram (mg) (a combination narcotic and over-the-counter pain medication) to be given every 12 hours as needed for pain. R1's MAR showed she only had one documented administration of hydrocodone-acetaminophen, which was on 2/14/26 at 2:34 PM. R1's MAR showed only this one order for hydrocodone-acetaminophen, which started on 11/11/25 and was discontinued on 3/4/26. On 4/2/26 at 10:22 AM, a record of all controlled substances delivered to the facility by the pharmacy was requested. The facility provided a sheet titled Daily Narcotic Usage. The sheet showed 60 tablets of hydrocodone-acetaminophen were delivered on 2/18/26 for R1. (At twice-daily administration, if given the maximum frequency, this delivery should have lasted 30 days; approximately March 20, 2026.) On 4/2/26 at 10:43 AM, V2 (Director of Nursing-DON) stated the facility was unable to locate R1's controlled substance count sheets for her HA. V2 stated R1 had 60 tablets of hydrocodone-acetaminophen delivered on 2/18/26 and these could not be accounted for. On 4/2/26 at 3:07 PM, V1 (Administrator) stated in hindsight this allegation should have been reported to the State Agency. V1 stated this allegation had not been reported to local law enforcement. The facility's Abuse Prevention Program (policy, reviewed 9/18/25) 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. The policy showed, 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. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. The facility shall also contact local law enforcement authorities (i.e., telephoning 911 where available) in the following situations.When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility failed to ensure accurate reconciliation and disposition of controlled substances. The facility also failed to have adequate policies for the reconciliation and disposition of controlled substances. These failures resulted in the facility being unable to account for a resident's controlled substances. This failure has the potential to affect all residents residing in the facility. The findings include:The facility provided census for 4/2/26 showed 65 residents resided at the facility. The facility's North Unit Controlled Substance Accountability Record Card-Sheet Count (commonly referred to as a card count sheet, CCS. The CCS is a count/record of the controlled substance cards, not the individual tablets. The facility also counted the controlled substance count sheets as well as the medication cards.) The facility was unable to produce the CCS for the North unit for the time period between the morning of 2/18/26 and the evening of 2/20/26. The following entries in the facility's CCS sheets were identified: 1.) 11/12/25 at 6:00 PM showed 1 controlled substance count sheet had been removed and 6 had been added for a total change of 5. The sheet showed there were 34 sheets at the beginning of the shift and 34 at the end (no change in the number of sheets despite a change of 5 sheets.) This error carried forward through 4 CCS counts until it was identified on 11/15/25 at 6:00 AM. 2.) 11/19/25 at 6:00 PM showed 1 sheet was removed and 3 sheets were added. The entry showed the start of this shift began with 35 and there were 39 at the end. (Based on the sheets added and removed, there should have been 37 sheets.) The 11/20/25 entry at 6:00 AM showed the shift started with 39 sheets then at the end of the shift there were 36 sheets. There were no documented sheet additions or subtractions during this shift. 3.) 1/30/26 at 6:00 PM showed the shift started with 45 sheets, 5 were added and the total sheets were 60 (should be 50). The next entry on 1/30/26 at 10:00 PM showed a write-over and the total sheets was 61 with no additions or subtractions. The following entry on 1/31/26 at 6:00 AM showed 51 sheets at the beginning and end of the shift with no additions or subtractions. 4.) The 2/8/26 entry at 6:00 AM showed 42 sheets were on hand at the beginning of the shift, one sheet was removed and there remained 42 sheets at the end of this shift (should be 41 sheets). On 2/9/26 at 2:00 PM the log showed another sheet removal, and the count was 41 (should be 40). These errors carried forward until, unexplainably, the 2/10/26 count at 6:00 showed the sheet count changed to 39. Additionally, the number of controlled substance bottles on 2/9/26 at 10:00 PM was 7 bottles with no additions or subtractions of bottles. The next entry on 2/10/26 at 6:00 AM showed there were now only 6 bottles (none had been documented removed/wasted.) 5.) 3/2/26 at 6:00 PM showed 40 sheets on hand and one sheet was added and one sheet was removed; however, there were 39 sheets at the end of the shift (should remain at 40). This error carried forward on the 3/2/26 at 10:00 PM entry until it was corrected on 3/3/26 at 6:00 AM. On 4/2/26 at 2:12 PM, V2 (Director of Nursing) described the nursing process for the CCS sheets and their purpose. V2 stated the CCS is a record of all controlled substance cards, bottles, and patches. V2 stated the CCS also tracks the number of controlled substance count sheets. (The controlled substance count sheets is a record for the number of pills in each card or the volume of liquid in the bottle.) V2 said the CCS errors identified on the sheet do not add up. V2 stated she was not aware of the controlled substance bottle discrepancy of 2/9/26 and she should have been notified. V2 stated the purpose of the CCS count is to prevent staff from taking the controlled substance count sheet and the corresponding card and the facility being unaware of the discrepancy (a deterrent). V2 said by having a running tally of all cards and sheets, it makes this scenario much more difficult to occur, and if it did occur, it would be identified at shift change. V2 stated the CCS, when completed, were placed in a folder in the copy room, staff would start a new sheet, and she would collect them. V2 was asked, because the CCS sheets only have room for 9 entries, or enough room for only 2-4 days of entries, and as soon as the sheets are completed they are removed from the nurses' cart what would prevent staff from taking the CCS sheet, the controlled substance count sheet, the corresponding (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	controlled substance card, and then just starting a new CCS sheet with a count that reflects what was in the cart? V2 replied there are no controls in place to prevent or catch this scenario. V2 stated there is a CCS count sheet missing during the time frame of R1's hydrocodone-acetaminophen medication being delivered on 2/18/26. V2 said the nurse reported her initials were forged on the next available CCS sheet following R1's hydrocodone-acetaminophen delivery. V2 said the facility was unable to determine when R1's hydrocodone-acetaminophen went missing and who possibly took the medications. (Most likely medications were removed between 2/18/26 and 2/20/26. They were not identified as missing until 3/4/26.) On 4/2/26 at 8:00 AM, the facility's controlled substance policy was requested. On 4/2/26 at 9:48 AM, the facility's Medication Administration policy (reviewed 1/30/26) was provided. The entirety of the controlled substance section is as follows, VII. Control Substances -Nurses shall take an additional step of signing out control substances on a controlled substance count sheet for each individual resident. - Nurses shall count the controlled substances at shift change and when handing off a cart if during a non-standard shift change. The count should be between the oncoming nurse and the off going nurse prior to turning over the keys. - Counts include individual resident counts and total number of cards/bottles and sheets. - Any time a new medication is delivered the nurse shall account for new card/bottle and sheet to count sheet. - Any time a card or bottle is empty the nurse shall account for the removal of the items on the count sheet. Any discrepancies shall be reported to the DON. The policy does not discuss wasting of controlled substances, who may waste controlled substances, or witnessing the wasting of controlled substances. The policy does not discuss the storage of controlled substances. The policy does not show what staff should do with completed CCS or controlled substance count sheets, who is responsible for maintaining the count sheets, and if any reconciliation should be done from one CCS sheet to the next. On 4/2/26 at 11:36 AM, V1 (Administrator) stated All we have for a controlled substance policy is what is in the medication policy.