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 04/16/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow policy for obtaining vital signs for residents receiving skilled services for 3 of 3 residents (R1, R2, R3) reviewed for quality of care in the sample of 5.The findings include: 1. On 4/16/26 at 10:57 AM, V5 Licensed Practical Nurse said R1 was in the skilled care unit for therapy for a fractured sacrum. V5 said R1 was receiving oxygen via nasal canula. V5 said vitals including blood pressure, pulse, temperature, respirations, and oxygen saturations are taken on residents in the skilled unit daily and as needed. V5 said when a resident is on oxygen it is important to check oxygen saturations to make sure the resident is getting the right amount of oxygen and vitals help show if a resident is experiencing a change in condition.On 4/16/26 at 11:51 AM, V2 Director of Nursing said residents at the facility for skilled therapy have a full assessment and vitals taken every 24 hours and as needed. V2 said if the resident is on oxygen there may be additional oxygen saturation checks ordered.R1's Facesheet shows R1 was admitted to the facility on [DATE] and discharged on 4/4/26.R1' Vitals Summary shows from 3/23/26-4/4/26 (13 days) R1's oxygenation saturation was checked once on 3/24/26. R1's pulse was checked 4 out of 13 days, blood pressure was checked 5 out of 13 days, respirations checked 5 out of 13 days, and temperature checked 6 out of 13 days.R1's Physician Orders shows an order dated 3/23/26 for 4 Liters oxygen nasal cannula due to history of shortness of breath and chronic obstructive pulmonary disease. These same orders do not contain any specific orders for checking oxygen saturation. 2. On 4/16/26 at 11:10 AM, R2 was sitting in a wheelchair in his room waiting for lunch. R2 said the staff checked his blood pressure today, but they don't do it every day, maybe every third day or so. R2's Facesheet shows R2 was admitted on [DATE] for skilled services.R2's Vitals summary shows out of the 34 days R2 has been at the facility R2's blood pressure has been checked 19 out of 34 days, oxygen saturation checked once, pulse checked 15 out of 34 days, respirations checked 15 out of 34 days, and temperature checked 16 out of 34 days.3. On 4/16/26 at 11:15 AM, R3 was sitting her wheelchair in her room. R3 said the staff check her pulse once in a while and they checked her blood pressure yesterday, but don't check that all the time. R3's Facesheet shows R3 was admitted to the facility on [DATE] for skilled services.R3's Vitals summary shows out of the 16 days that R3 has been at the facility R3's blood pressure was checked 9 out of 16 days, pulse was checked 9 out of 16 days, oxygen saturation was checked once, respirations were checked 7 out of 16 days, and temperature was checked 8 out of 16 days.The facility's Resident Examination and Assessment Policy dated 3/21/25 shows the purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. Residents receiving skilled services will have an assessment completed at least once per shift. Focused system-specific assessment- respiratory: increased work of breathing, oxygen saturation, lung sounds, cough characteristics. 1. Vital signs: blood pressure, pulse, respiration, temperature.

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident's pain was managed for 1 of 3 (R1) residents reviewed for pain in the sample of 5. The findings include: On 4/16/26 at 10:57 AM, V5 Licensed Practical Nurse (LPN) said R1 was in the skilled unit at the facility for therapy for a fractured sacrum. V5 said R1 was in a lot of pain and anxiety. V5 said R1 had hydrocodone-acetaminophen prescribed for pain.On 4/16/26 at 9:20 AM, V8 Complainant (R1's sister in law) said the facility was not meeting R1's needs by not controlling R1's pain.R1's Hospital Discharge Instructions dated 3/23/26 shows R1 was admitted to the hospital with acute hypoxic respiratory failure and a pelvic fracture after a fall on driveway. Orthopedics recommended a non-operative plan for now, as R1 is a high risk for surgery due to fragile respiratory status. Medication list: Hydrocodone-acetaminophen 10-325 mg tablet by mouth every 4 hours as needed for moderate pain.R1's Progress Note by V9 Medical doctor, dated 3/26/26 shows Patient very uncomfortable, and I think there is a significant amount of anxiety. We will try to stay in front of his pain and obviously therapy within the facility will be paramount to his success.On 4/16/26 at 9:54 AM, V3 LPN said when R1 was admitted the wrong dose of hydrocodone-acetaminophen was ordered (5/325 mg) which was not helping R1's pain. V3 said we got the order changed to the correct dose of hydrocodone-acetaminphen10/325 mg.R1's Progress Note dated 3/26.26 shows This nurse was made aware that resident's pain is not being well controlled with the current as needed hydrocodone-acetaminophen 5/325mg every 4 hours. After some investigation, it was discovered that the hospital discharge paperwork had the order hydrocodone-acetaminophen for 10-325mg every 4 hours as needed. After calling the pharmacy and speaking with V9 the ok was given to change the order to hydrocodone-acetaminophen 10-325 mg every 4 hours as needed for moderate pain.R1's Pain assessment dated [DATE] shows Over the last 5 days how much of the time has pain made it hard for you to sleep at night: Frequently. Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain: Almost constantly.R1's Medication Administration Record (MAR) for March 2026 shows that R1 received hydrocodone-acetaminophen 5/325 mg, give 1 tablet every 4 hours as needed for pain from 3/25/25 to 3/30/26. This same MAR shows R1 started receiving hydrocodone-acetaminophen 10/325 mg, give 1 tablet every 6 hours as needed for pain on 3/31/26 (still not the correct admission order of hydrocodone-acetaminophen 10/325 mg, every 4 hours). This same MAR shows R1's pain levels before administering the medications were documented as 5-9 out of 10.R1's Nurse Practitioner Progress Note dated 3/29/26 shows Patient is at facility for subacute rehab following a fall at home with multiple rib fractures. Patient is resting in his bed for today's visit. He reports that he is having a lot of pain, it is difficult for him to move and participate in activities. He's having trouble sleeping because of his pain and his mood is poor due to his current physical condition.R1's After Visit Summary from the Orthopedic Doctor dated 3/31/26 shows Your medication list: hydrocodone-acetaminophen 10-325 mg Take one tablet every 4 hours as needed for moderate pain (confirming R1's pain medication should be every 4 hours).R1's Pain assessment dated [DATE] shows : Over the past 5 days, how much of the time has pain made it hard for you to sleep at night: Almost constantly. Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain: Occasionally. Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain: Almost constantly. Pain intensity: 9.R1?s MAR for April 2026 still has the incorrect order of hydrocodone-acetaminophen 10/325 mg, give 1 tablet every 6 hours as needed for pain, which was administered until family initiated R1's discharge on [DATE].On 4/16/26 at 2:30 PM, V2, (DON) Director of Nursing said R1's admitting orders for R1 was hydrocodone-acetaminophen 10/325 every 4 hours but V9 (R1's doctor at the facility) had called in the order for hydrocodone-acetaminophen (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/325 mg as needed every 4 hours. V2 said the facility had got the correct orders but the doctor called in hydrocodone-acetaminophen 10/325 mg every 6 hours instead of every 4 hours. V2 said the staff sent a fax to verify the order with V9 but did not get a response back and did not follow up. V2 said that is why R1's MAR shows as 10/ hydrocodone-acetaminophen 325 every 6 hours. V2 said staff should have followed up with V9 to clarify the order since R1 was having pain.The facility's Pain Management Policy dated 4/11/26 shows to ensure all residents receive timely, appropriate, and effective pain assessment and management in order to maintain the highest practicable level of comfort, function, and quality of life. Administer medications as ordered, including scheduled and as needed medications.