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	07/31/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 35541 Based on observation, interview and record review the facility failed to ensure professional standards were met by nursing during medication administration. This failure applies to 1 of 3 residents (R23) observed in the medication pass. The findings include: R23's July 2024 Medication Administration Record (MAR) showed medication orders for R23 as the following: a) Depakote 250 mg (milligrams) Delayed Release, give 250 mg by mouth, two times a day at 8 AM and 8 PM, for depression. b) Lantus insulin 100 unit/ml (milliliter), inject 35 units subcutaneously (SQ), two times a day at 8 AM and 8 PM, for Type 2 Diabetes Mellitus. c) Fiasp insulin, 100 unit/ml, inject 14 units SQ, before meals at 7:30 AM, 11:30 AM, 5:30 PM, for Type 2 Diabetes Mellitus. The MAR showed a second order for R23 to also receive Fiasp insulin, SQ, per sliding scale based on R23's glucose level (if glucose is 100-150, give 2 units; 151-200, give 4 units, 201-250, give 6 units; 251-300, give 8 units), before meals and at bedtime, at 7:30 AM, 11:30 AM, 5:30 PM, 8 PM. d) Norco 5/325 mg, give one tablet, three times a day at 8 AM, 2 PM, 10 PM, for low back pain. e) Pregabalin (Lyrica) 200 mg, give 1 capsule, three times a day at 8 AM, 12 PM, 8 PM, for nerve pain related to diabetic neuropathy. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 9:34 AM, V6 (Licensed Practical Nurse/LPN) dispensed R23's morning medications into a cup which included one tablet of Depakote 250 mg (milligrams), one tablet of Lyrica 200 mg, and one tablet of Norco 5/325 mg. As V6 (LPN) dispensed R23's pills, V3 (Wound Nurse) stood next to V6, talking to facility staff as they walked by. V6 (LPN) handed the cup of R23's pills to V3 (Wound Nurse). V6 (LPN) made no attempt to review R23's medications, she had dispensed into the cup, with V3. At 9:37 AM, V3 (Wound Nurse) walked outside to R23 and handed the cup of pills to R23. As R23 was swallowing his pills, V3 (Wound Nurse) checked R23's blood glucose level. The blood glucose machine showed R23's blood glucose level as 260 milligrams/deciliter (mg/dl). V3 (Wound Nurse) then walked back inside the building and reported R23's blood glucose level to V6 (LPN). At 9:42 AM, V6 (LPN) prepped R23's Fiasp insulin pen to administer 22 units of Fiasp insulin. V6 (LPN) prepped R23's Lantus insulin pen to administer 35 units of Lantus insulin. V6 (LPN) made no attempt to double check the dosages of either of R23's insulin pens with V3 (Wound Nurse). V6 (LPN) then handed both of R23's insulin pens to V3 (Wound Nurse). At 9:45 AM, V3 (Wound Nurse) walked back outside to R23 and administered R23's Fiasp and Lantus insulins to R23. On 7/29/24 at 10:56 AM, V3 (Wound Nurse) stated, Normally the nurse that draws up the meds (medications), gives the meds to make sure everything is correct. I was just trying to help out. On 7/30/24 at 9:08 AM, V2 (Director of Nursing) stated, The nurse that draws up any medication is the nurse that must give those meds. That is the only way to be one hundred percent sure of how much med was drawn up and who the med is for. The facility's Insulin Administration policy dated 7/28/23 showed, To provide guidelines for the safe administration of insulin to residents with diabetes . Only the person who draws up the insulin for injection can inject it . The facility's Medication Administration policy dated 7/28/23 showed, The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798 Based on observation, interview, and record review, the facility failed to ensure a resident with dysphagia was assessed by speech therapy after a choking episode and failed to ensure residents were transferred in a safe manner. These failures apply to 3 of 17 residents (R10, R51, R40) reviewed for safety and supervision in the sample of 17. The findings include: 1. R10's Admission Record dated 7/29/24 shows R10's diagnoses include, but are not limited to, Parkinsonism, tracheostomy status, gastro-esophageal reflux disease, dysphagia, seizures, and traumatic brain injury. R10's Minimum Data Set, dated dated [DATE] under the heading Swallowing Disorder, shows R10 has coughing or choking during meals or when swallowing medications. R10's Progress notes dated 3/13/24 at 6:33 PM show R10 was coughing with food in her mouth and three nurses attempted to assist R10 to clear her airway. R10 was getting air through her stoma (tracheostomy) and was finally able to clear her airway. R10 had abnormal lung sounds and was sent to the hospital for evaluation. On 07/30/24 at 8:08 AM, R10 was eating breakfast in the dining room and noted to be coughing during her meal. On 7/30/24 at 8:11 AM, V10, (Speech Language Pathologist/SLP) said R10 was having trouble swallowing and was coughing during meals so nursing referred R10 to ST (speech therapy) in October of 2023. R10 was discharged from ST in November of 2023 with safe swallowing strategies. V10 said R10 has not been seen by ST since she was discharged (from ST) in November of 2023. V10 said she was not aware R10 had a choking episode in March of 2024. V10 said R10 should have been referred to ST to have an evaluation if she had a significant choking episode. V10 said she would have done an evaluation and probably would have ordered a video swallow had she known about R10's choking incident. On 7/31/24 at 10:33 AM, V14, (Licensed Practical Nurse/LPN), said she was summoned to the dining room because R10 was having trouble eating, had a piece of food lodged in her throat and was coughing. V14 said R10 was still able to breathe through her trach and she was eventually able to clear the obstruction by coughing. V14 said she cannot remember if she got a ST evaluation for R10 after she was choking on her food. V14 said if a resident has dysphasia then she would definitely get a ST referral if there was a choking incident. On 7/30/24 at 2:08 PM, V2, (Director of Nursing), said R10 was eating too quickly and she choked on her food. V2 said R10 was coughing and trying to get the food out and was having issues to clear the food on her own. V2 said R10 was sent out to the hospital and evaluated. V2 said R10 did not have any diet changes after she choked and she was not referred back to ST. V2 said R10 has dysphagia and has a history of a trach, with a stoma at this time. The facility's Safety and Supervision of Residents Policy (reviewed 5/17/24) shows when accident hazards are identified, the cause of the hazard shall be evaluated and analyzed to develop strategies to mitigate or remove the hazard to the extent possible. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	35541 2. R51's current care plan showed R51 has limited physical mobility and was at risk for falls due to his diagnoses of dementia, muscle weakness, and activity intolerance. The plan showed R51 required staff assistance with use of a gait belt for ambulation and transfers. On 7/29/24 at 12:07 PM, R51 was seated in a recliner in his room as V7 (Certified Nursing Assistant/CNA) stood next to him. A wheeled walker was noted directly in front of R51. V7 (CNA) asked R51 to stand up from his recliner so she could provide R51 with cares as he was incontinent of stool. V7 assisted R51 to standing by holding onto R51's left arm. No gait belt was used to stand R51. Once standing, V7 let go of R51's arm and began providing R51 with incontinence care. No gait belt was placed on R51 as he stood. R51 stood, holding onto his walker. At 12:10 PM, R51 remained standing as V7 continued to provide him with incontinence care. R51 stated, I need to sit soon. My legs are tired. V7 stated, Ok, just give me one more minute. At 12:11 PM, R51 stated, I have to sit. R51 slowly leaned back into the recliner, unassisted by V7. On 7/30/24 at 11:57 AM, V2 (Director of Nursing) stated staff are to use gait belts on residents that require staff assistance to walk and/or transfer. The facility's Safe Lifting and Movement of Residents policy dated 7/28/23 showed, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to left and move residents .Gait belts shall be used on residents unless residents are independent with ambulation or contraindicated in the resident's care plan . 3. A Fall During Staff Assist incident report dated 7/10/24 showed R40 was found by a nurse lying on the floor next to his bed. The report showed, CNA (V8) stated she was transferring resident from wheelchair to bed, when sitting the resident on bed, bed rolled away from patient. The report R40 received no injuries from the fall. On 7/30/24 at 10:17 AM, V8 (CNA) stated, I went to transfer (R40) and the bed began to roll as I set him on the bed. I got him on the bed, but he fell forward which made the bed roll even more so I just lowered him to the ground. I made sure the wheels of the wheelchair were locked but I didn't check that the wheels were locked on the bed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35541 Based on observation, interview and record review the facility failed to maintain a resident's urinary catheter tubing and urinary drainage bag below the level of a resident's bladder to prevent infection for 1 of 4 residents (R51) reviewed for urinary catheter care in the sample of 17. The findings include: R51's current care plan showed R51 had a urinary catheter in place due to his diagnoses of urinary incontinence and neuromuscular dysfunction of his bladder. The care plan showed, Position catheter bag and tubing below the level of the bladder . On 7/29/24 at 12:03 PM, R51 was seated in a recliner in his room with V7 (Certified Nursing Assistant/CNA) standing next to R51. V7 held R51's urinary catheter bag at her waist (at the level of R51's head) as R51 attempted to reposition himself in the recliner. An obvious backflow of urine was noted in the catheter tubing, towards R51. On 7/30/24 at 11:57 AM, V2 (Director of Nursing) stated a resident's urinary catheter bag and tubing is to be kept below the level of the resident's bladder so there is no backflow of urine which could cause a UTI (urinary tract infection). The facility's Urinary Catheter Care policy dated 9/29/23 showed, The purpose of this procedure is to prevent catheter-associated urinary tract infections . The urinary drainage bag must be held or positioned lower that the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798 Based on observation, interview, and record review, the facility failed to ensure residents were monitored during medication administration for 2 of 17 residents (R53, R19) reviewed for medication administration in the sample of 17. The findings include: On 7/29/24 at 9:58 AM, R53 was lying in bed in her room. An orange pill was sitting on R53's bedside table in a medicine cup. R53 said the nurse brought her medications, but she doesn't want to take that pill today and she needs to throw it away. R53's Admission Record dated 7/29/24 shows R53 was admitted to the facility on [DATE] with a principle admitting diagnosis of dementia. On 7/29/24 at 10:05 AM, R19 was sitting in a chair next to his bed. A pill was in a medicine cup on his bed. R19 said the pill is for the pain in his feet. R19 said the nurse brings his medication in when he is still sleeping and leaves it. R19 said his pain starts in the afternoon, so he will keep it and take it later. R19 said he gets the medication (which he said is Gabapentin) three times a day and staff know he takes them this way. On 7/30/24 at 9:19 AM, V2, (Director of Nursing), said the nurse needs to watch the residents take their medications to make sure they are swallowed. If the resident does not want to take their medications, then the nurse need to document the refusal, if the resident wants to take their medications at a different time, the nurse needs to contact the doctor and have the order changed. V2 said it's not ok to leave medications for the residents to take when they want. The facility's Self-Administration of Medications Policy (reviewed 7/28/23) shows residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The staff and practitioner will assess the resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate and document their findings. The facility was not able to provide documentation of an assessment for R19 or R53 regarding self-administration of medications.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35541 Based on interview and record review the facility failed to respond to the pharmacist's notification that a resident's PRN (as needed) anti-anxiety medication order had no end date. This failure applies to 1 of 5 residents (R6) reviewed for psychotropic medications in the sample of 17. The findings include: R6's Order Summary Report showed a new physician order, dated 4/5/24, for R6 to receive Lorazepam (anti-anxiety medication) 0.5 mg (milligrams), every 4 hours as needed (PRN) for anxiety. The report showed no stop date for the medication. R6's Pharmacy Consultant Medication Regimen Review assessments dated 4/25/24, 5/16/24, and 6/21/24 each showed V17 Consulting Pharmacist repeatedly requested a stop date for R6's PRN Lorazepam order dated 4/5/24. R6's Note to Attending Physician/Prescriber form dated 6/23/24 showed, 3rd request Resident has a PRN psychotropic order, Ativan (Lorazepam) 0.5 mg q4 hours PRN, but does not have criteria in place for use beyond 14 days. The form showed R6's physician renewed the Lorazepam order due to R6's agitation and psychosis. On 7/31/23 at 9:12 AM, V2 (Director of Nursing) stated any pharmacist recommendations noted on a resident's monthly medication review should be implement within 48-72 hours of receiving the recommendations. On 7/31/24 at 11:24 AM, V17 (Consulting Pharmacist) stated any new physician order for a PRN psychotropic medication or anti-anxiety medication needs an end date of fourteen days from the date the prescription is started. V17 stated, After fourteen days, the physician is to evaluate the resident for the need to continue to the medication I would expect that the facility has acted upon my recommendations, that I made on my review, by the time I return to do my next monthly medication review. If I return the next month and my recommendations have not been acted upon, I keep re-issuing the same recommendations. The facility's Psychotropic Medication policy dated 4/9/24 defined Psychotropic medications as a medication that is used for or listed as used for antipsychotic, antidepressant, antimonic, antianxiety, behavior modification, or behavior management purposes. The policy showed, It is the policy of this facility that residents shall not be given unnecessary drugs . The policy showed new PRN orders for psychotropics medications have a time limit of fourteen days. After the fourteen days, the prescribing physician can write a new order for the medication if he/she determines the continued use of the medication is warranted.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47552 Based on interview and record review the facility failed to ensure as needed (PRN) anti-psychotic medications had a stop date of fourteen days. This applies to 2 of 5 residents (R56, R6) reviewed for unnecessary medications in the sample of 17. The findings include: 1. R56's Order Summary Report dated 7/30/24 shows lorazepam oral concentrate 2 MG/ML (milligrams per milliliter), give 0.25 mL (milliliters) by mouth every 2 hours as needed for agitation related to unspecified psychosis not due to a substance or known physiological condition. R56's order for lorazepam has a start date of 12/29/23 and does not have a stop date. 35541 2. R6's Order Summary Report showed a new physician order, dated 4/5/24, for R6 to receive Lorazepam (anti-anxiety medication) 0.5 mg (milligrams), every 4 hours as needed (PRN) for anxiety. The report showed no stop date for the medication. R6's Pharmacy Consultant Medication Regimen Review assessments dated 4/25/24, 5/16/24, and 6/21/24 each showed V17 (Consulting Pharmacist) repeatedly requested a stop date for R6's PRN Lorazepam order dated 4/5/24. R6's Note to Attending Physician/Prescriber form dated 6/23/24 showed, 3rd request Resident has a PRN psychotropic order, Ativan (Lorazepam) 0.5 mg q4 hours PRN, but does not have criteria in place for use beyond 14 days. The form showed R6's physician renewed the Lorazepam order due to R6's agitation and psychosis. On 7/31/24 at 11:24 AM, V17 (Consulting Pharmacist) stated any new physician order for a PRN psychotropic medication or anti-anxiety medication needs an end date of fourteen days from the date the prescription is started. V17 stated, After fourteen days, the physician is to evaluate the resident for the need to continue to the medication. The facility's Psychotropic Medication policy dated 4/9/24 defined Psychotropic medications as a medication that is used for or listed as used for antipsychotic, antidepressant, antimonic, antianxiety, behavior modification, or behavior management purposes. The policy showed, It is the policy of this facility that residents shall not be given unnecessary drugs . The policy showed new PRN orders for psychotropics medications have a time limit of fourteen days. After the fourteen days, the prescribing physician can write a new order for the medication if he/she determines the continued use of the medication is warranted.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 35541 Based on observation, interview and record review the facility failed to administer medications on time and as ordered. There were 28 medication administration opportunities with 5 errors resulting in a 17.86% error rate. This failure applies to 1 of 3 residents (R23) observed in the medication pass. The findings include: R23's July 2024 Medication Administration Record (MAR) showed medication orders for R23 as the following: a) Depakote 250 mg (milligrams) Delayed Release, give 250 mg by mouth, two times a day at 8 AM and 8 PM, for depression. b) Lantus insulin 100 unit/ml (milliliter), inject 35 units subcutaneously (SQ), two times a day at 8 AM and 8 PM, for Type 2 Diabetes Mellitus. c) Fiasp insulin, 100 unit/ml, inject 14 units SQ, before meals at 7:30 AM, 11:30 AM, 5:30 PM, for Type 2 Diabetes Mellitus. The MAR showed a second order for R23 to also receive Fiasp insulin, SQ, per sliding scale based on R23's glucose level (if glucose is 100-150, give 2 units; 151-200, give 4 units, 201-250, give 6 units; 251-300, give 8 units), before meals and at bedtime, at 7:30 AM, 11:30 AM, 5:30 PM, 8 PM. d) Norco 5/325 mg, give one tablet, three times a day at 8 AM, 2 PM, 10 PM, for low back pain. e) Pregabalin (Lyrica) 200 mg, give 1 capsule, three times a day at 8 AM, 12 PM, 8 PM, for nerve pain related to diabetic neuropathy. On 7/29/24 at 9:18 AM, R23 was seated in a wheelchair in his room. R23 stated, I am waiting to get my meds (medications). They are late. I haven't had any of my morning meds yet. I am sitting here waiting and no one has come. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 9:34 AM, V6 (Licensed Practical Nurse/LPN) dispensed R23's morning medications into a cup which included one tablet of Depakote 250 mg (milligrams), one tablet of Lyrica 200 mg, and one tablet of Norco 5/325 mg. V6 (LPN) handed the cup of R23's pills to V3 (Wound Nurse). At 9:37 AM, V3 (Wound Nurse) walked outside to R23 and handed the cup of pills to R23. As R23 was swallowing his pills, V3 (Wound Nurse) checked R23's blood glucose level. The blood glucose machine showed R23's blood glucose level as 260 milligrams/deciliter (mg/dl). V3 (Wound Nurse) then walked back inside the building and reported R23's blood glucose level to V6 (LPN). At 9:42 AM, V6 (LPN) prepped R23's Fiasp insulin pen to administer 22 units of Fiasp insulin. V6 (LPN) prepped R23's Lantus insulin pen to administer 35 units of Lantus insulin. V6 (LPN) then handed both of R23's insulin pens to V3 (Wound Nurse). V6 (LPN) was asked why R23's medications were being administered late, V6 stated, I don't really know these residents on this wing so I'm behind. Yes, (R23's) insulin should have been given to him before he ate breakfast. At 9:45 AM, V3 (Wound Nurse) administered R23's Fiasp and Lantus insulins to R23. As V3 was administering R23's insulin, R23 was asked if he had eaten breakfast, R23 stated, I ate breakfast a while ago. On 7/30/24 at 9:08 AM, V2 (Director of Nursing/DON) stated a resident's blood glucose level should be checked thirty minutes prior to a meal because we want a fasting blood sugar to account for the amount of short acting insulin that should be given. V2 stated all medications should be administered as ordered by a physician. V2 stated medications are to be administered no later than one hour after its scheduled time or the medication administration is considered late. The facility's Medication Administration policy dated 7/28/23 showed, Medications shall be administered in a safe and timely manner, and as prescribed . Medications must be administered in accordance with the orders, including required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 35541 Based on observation, interview and record review the facility failed to ensure residents' medications were administered as prescribed to avoid significant medication errors for 2 of 17 residents (R23, R25) reviewed for medication administration errors in the sample of 17. The findings include: 1. R23's July 2024 Medication Administration Record (MAR) showed medication orders for R23 as the following: a) Depakote 250 mg (milligrams) Delayed Release, give 250 mg by mouth, two times a day at 8 AM and 8 PM, for depression. b) Lantus insulin 100 unit/ml (milliliter), inject 35 units subcutaneously (SQ), two times a day at 8 AM and 8 PM, for Type 2 Diabetes Mellitus. c) Fiasp insulin, 100 unit/ml, inject 14 units SQ, before meals at 7:30 AM, 11:30 AM, 5:30 PM, for Type 2 Diabetes Mellitus. The MAR showed a second order for R23 to also receive Fiasp insulin, SQ, per sliding scale based on R23's glucose level (if glucose is 100-150, give 2 units; 151-200, give 4 units, 201-250, give 6 units; 251-300, give 8 units), before meals and at bedtime, at 7:30 AM, 11:30 AM, 5:30 PM, 8 PM. d) Norco 5/325 mg, give one tablet, three times a day at 8 AM, 2 PM, 10 PM, for low back pain. e) Pregabalin (Lyrica) 200 mg, give 1 capsule, three times a day at 8 AM, 12 PM, 8 PM, for nerve pain related to diabetic neuropathy. On 7/29/24 at 9:18 AM, R23 was seated in a wheelchair in his room. R23 stated, I am waiting to get my meds (medications). They are late. I haven't had any of my morning meds yet. I am sitting here waiting and no one has come. On 7/29/24 at 9:34 AM, V6 (Licensed Practical Nurse/LPN) dispensed R23's morning medications into a cup which included one tablet of Depakote 250 mg (milligrams), one tablet of Lyrica 200 mg, and one tablet of Norco 5/325 mg. V6 (LPN) handed the cup of R23's pills to V3 (Wound Nurse). At 9:37 AM, V3 (Wound Nurse) walked outside to R23 and handed the cup of pills to R23. As R23 was swallowing his pills, V3 (Wound Nurse) checked R23's blood glucose level. The blood glucose machine showed R23's blood glucose level as 260 milligrams/deciliter (mg/dl). V3 (Wound Nurse) then walked back inside the building and reported R23's blood glucose level to V6 (LPN). At 9:42 AM, V6 (LPN) prepped R23's Fiasp insulin pen to administer 22 units of Fiasp insulin. V6 (LPN) prepped R23's Lantus insulin pen to administer 35 units of Lantus insulin. V6 (LPN) then handed both of R23's insulin pens to V3 (Wound Nurse). V6 (LPN) was asked why R23's medications were being administered late, V6 stated, I don't really know these residents on this wing so I'm behind. Yes, (R23's) insulin should have been given to him before he ate breakfast. At 9:45 AM, V3 (Wound Nurse) administered R23's Fiasp and Lantus insulins to R23. As V3 was administering R23's insulin, R23 was asked if he had eaten breakfast, R23 stated, I ate breakfast a while ago. (continued on next page)

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Oregon Living and Rehabilitation Center	811 South 10th Street Oregon, IL 61061

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 9:08 AM, V2 (Director of Nursing/DON) stated a resident's blood glucose level should be checked thirty minutes prior to a meal because we want a fasting blood sugar to account for the amount of short-acting insulin that should be given. V2 stated, Staff should administer all medications as ordered by the physician. If meds aren't given as prescribed, it could cause a change in the resident's condition. Schedule pain medications should be given at the prescribed time for pain management. V2 stated medications are to be administered no later than one hour after its scheduled time or the medication administration is considered late. 2. R25's January 2024 Controlled Substance record showed a physician order, dated 1/18/24, for R25 to receive Tramadol (pain medication) 50 mg, take one tablet every 6 hours PRN (as needed) for pain. R25's Nursing Note dated 1/29/24 showed V5 (former nurse) administered extra doses of Tramadol to the resident for a total of 4 tablets of 50 mg Tramadol. The note showed R25 was administered 200 mg of Tramadol in total. The note showed R25's physician was notified of the incident. R25 was monitored for serious side effects with no adverse effects noted from the incident. On 7/30/24 at 9:18 AM, V2 (DON) stated, (V5 former nurse) no longer works here. The incident with (R25) was one of the reasons we let (V5) go. (V5) must not have been paying attention when she was preparing (R25's) medications that day because she put 4 pills of Tramadol in the cup to give to (R25). (R25) ended up getting 200 mg of Tramadol. (V5) didn't even realize she had made a mistake until the end of her shift, when she was counting narcotics with the oncoming night nurse. (R25's) Tramadol count was off. The facility's Medication Administration policy dated 7/28/23 showed, Medications shall be administered in a safe and timely manner, and as prescribed . Medications must be administered in accordance with the orders, including required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35541 Based on observation, interview and record review the facility failed to ensure opened, multi-dose vials/bottles of medication, including insulin pens and eye drops, were labeled with expiration dates for 5 of 5 residents (R15, R23, R41, R59, R14) reviewed for medication storage in the sample of 17. The finding include: R15's July 2024 Order Summary Report showed a physician order for R15 to receive 40 units of Glargine insulin, SQ (subcutaneously), twice a day. R23's July 2024 Order Summary Report showed a physician order for R23 to receive 14 units of Fiasp insulin, SQ, three times a day, before meals. R41's July 2024 Order Summary Report showed physician orders for R41 to receive 100 units of Tresiba insulin, SQ, at bedtime, and 6 units of Lispro insulin, SQ, before meals and at bedtime. R59's July 2024 Order Summary Report showed a physician order for R59 to receive 55 units of Lantus insulin, SQ, twice a day. R14's July 2024 Order Summary Report showed a physician order for R14 to receive one drop of Latanoprost eye drops, to both eyes, once a day at bedtime. On 7/29/24 at 9:50 AM, the 100-wing medication cart of the facility was reviewed with V2 (Director of Nursing/DON). The following medications were found opened, with no identified expiration dates, by this surveyor and V2 (DON): one Glargine insulin pen for R15, one Fiasp insulin pen for R23, one Tresiba insulin pen and one Lispro insulin pen for R41, one Lantus insulin pen for R59, and one bottle of Latanoprost eye drops for R14. V2 (DON) stated insulin pens and bottles of eye drops are to be dated when opened so staff know when the medication expires. The facility's Medication Administration policy dated 7/28/23 showed, The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. The facility's Insulin Administration policy dated 7/28/23 showed, Check the expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date on the vial .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47552 Based on observation, interview, and record review the facility failed to ensure residents receiving a pureed diet received a full four ounce (oz) scoop of pureed hamburger. This applies to 4 of 4 residents (R26, R24, R8, R55) reviewed for pureed diets in the sample of 17. The findings include: Facility Diet Type Report shows R26, R24, R8, and R55 receive pureed diets. Facility provided list of residents that use a three-compartment plate shows R26, R24, R8, and R55 receive their pureed meals in a three-compartment plate. On 7/29/24 at 11:59 PM, pureed bread, mashed potatoes, pureed green beans, and pureed hamburger were at the service line for pureed residents. The mashed potatoes, pureed green beans, and pureed hamburgers all had a 4 oz scoop. The pureed bread had a 1 oz scoop. All scoops were the correct sizes. On 7/29/24 between 12:00 PM and 12:45 PM, V15 (Cook) served and plated lunch for the facility. The portion sizes for residents receiving pureed foods in three-compartment plates appeared small. V15 would place the pureed bread and pureed hamburger in one compartment, the pureed green beans in the second compartment, and the mashed potato in the third compartment. On 7/29/24 at 12:58 PM, facility provided test tray of the pureed meal consisted of green beans in one compartment, mashed potatoes in the second compartment, and the pureed bread and pureed hamburger sharing the third compartment. On 7/29/24 at 1:40 PM, V15 said to accommodate putting all four pureed items into the three-compartment plate, V15 put one full scoop of pureed bread and approximately a half scoop of pureed hamburger into the same section. On 7/31/24 at 11:35 AM, V14 (Dietary Manager) said V15 should have provided each resident with one full scoop of pureed hamburger.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47552 Based on observation, interview, and record review the facility failed to ensure dishes were submerged in the sanitizing sink for at least 60 seconds and failed to ensure sanitized dishes were handled with clean hands. This has the potential to effect all 66 residents residing in the facility. The findings include: The CMS 671 dated 7/29/24 shows that there are 66 residents residing in the facility. Facility provided Diet Type Report dated 7/30/24 shows that there are no residents that receive a tube feeding and all residents receive food and drinks from the dietary department. 1. On 7/29/24 at 9:27 AM, V12 (Dietary Manager) used a chemical sanitizer test strip on a coffee mug after a cycle through the dish machine and the test strip showed there was no sanitizer being run through the machine. At 9:31 AM, V12 tried a second attempt and the test strip still showed there was no sanitizer being run through the machine. V12 then went to get maintenance to fix the dish machine. If the dish machine cannot be fixed, V12 said that staff will use the three-compartment sink to wash and sanitize the dishes until it gets fixed. On 7/29/24 at 9:35 AM, V16 (Dietary Aide) said the dish machine sanitizer concentration was tested at around 9:15 AM and read 100 parts per million (ppm). On 7/29/24 at 10:06 AM, V12 told V16 to start using the three-compartment sink to get the dishes from breakfast washed. On 7/29/24 at 10:17 AM, V16 began washing four water pitchers with lids in the three compartment sink. After washing and rinsing the first pitcher, V16 dipped it in the third sink filled with sanitizer solution, removed it immediately, and placed it in a rack to dry. V16 did the same thing with the second and third pitchers. With the fourth pitcher, V16 dipped the pitcher twice and removed it from the sanitizer sink and placed it in a rack to dry. When finished with the pitchers, V16 washed the pitcher lids in the first sink, tossed them into the sanitizer sink, and removed them after less than 30 seconds in the sanitizer solution. At 10:29 AM, V16 began to remove the pitchers with lids from the rack to put them away. When V16 grabbed two of the pitcher lids, they fell from V16's hands and into the garbage underneath the three-compartment sink where they were left to dry. V16 proceeded to grab the pitcher lids from the garbage, put the lids into the wash sink, and continued to put away the rest of the sanitized dishes left on the rack without washing her hands. On 7/29/24 at 11:03 AM, V12 said employees should wash their hands before handling sanitized dishes after they have touched or handled the trash. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 7/29/24 at 11:16 AM, V15 (Cook) began to puree food for lunch. V15 started with the hamburgers. At 11:28 AM, V15 finished the pureed hamburgers and brought the food processor container, food processor lid, and food processor blade to the three-compartment sink. V15 first washed and rinsed the food processor container and placed it into the sanitizer solution. V15 then washed and rinsed the lid and the blade and placed them into the sanitizer solution. All items were removed at 11:30 AM and the blade and lid were left in the sanitizer solution for less than 30 seconds. On 7/29/24 at 11:32 AM, V15 began to puree the green beans for lunch. At 11:37 AM, when finished with the green beans, V15 brought the food processor container, food processor lid, and food processor blade to the three-compartment sink. V15 started with washing and rinsing the food processor lid and placing it into the sanitizer solution. V15 then washes and rinses the blade and places it into the sanitizer solution. V15 washed and rinsed the food processor container and then placed it into the sanitizer solution. V15 removed the food processor container after approximately being in the sanitizer solution for ten seconds while all other items remained in the solution for at least one minute. On 7/29/24 at 11:03 AM, V12 said items should be submerged in the sanitizer solution for at least 60 seconds before being removed. Facility Cleaning Dishes - Manual Dishwashing policy dated 5/18/2017 states, . Sanitize dishes: . 3. Place the dishes in the sanitizing sink. Allow to stand according to the manufacturer's guidelines for sanitizer (or see chart below) . The below chart states when quaternary ammonium sanitizer is used, the necessary contact time is per the manufacturer. Product label for the facility sanitizer states, Food Contact Surface Sanitizing Performance: This product is an effective food contact sanitizer in 1 minute at 1 fl. oz. (fluid ounce) per 4 gal. (gallon) of 500 ppm (parts per million) hard water (200 ppm active) on hard non-porous surfaces .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on observation, interview and record review the facility failed to implement and follow Enhanced Barrier Precautions (EBP) for 4 of 17 residents (R51, R10, R13, R14) reviewed for infection control in the sample of 17. The findings include: 1. R51's current care plan showed R51 required Enhanced Barrier Precautions related to his urinary catheter. On 7/29/24 at 12:03 PM, this surveyor knocked on R51's door and entered his room. No signage, identifying R51 was on EBP, was noted on or around R51's door. No cart containing PPE (personal protective equipment) was noted by the doorway to R51's room. Upon entrance to the room, R51 was seated in a recliner as V7 (Certified Nursing Assistant/CNA) stood next to R51, holding onto R51's urinary catheter. V7 wore a mask and gloves but had no protective gown on. Once V7 repositioned himself in the recliner, V7 (CNA) left the room to obtain supplies to provide cares to R51 as he was incontinent of a large amount of mushy stool. At 12:07 PM, V7 (CNA) returned to R51's room and began providing incontinence care to R51. V7 wore a mask and gloves as she provided cares to R51 but did not don a protective gown. On 7/30/24 at 11:01 AM, V2 (Director of Nursing) stated R51 is on Enhanced Barrier Precautions due to the urinary catheter he has in place. V2 stated, Residents that have catheters, indwelling medical devices, wounds, a tracheostomy, or pressure injuries should be on EBP. Staff should know if a resident is on EBP because there is an orange dragonfly sign taped next to their name on the door of their room. We don't use actual EBP signs. If a resident is on EBP, staff are to wear a gown, gloves, and a mask when providing cares to that resident. Isolation supplies (PPE) should be in a cart close to the resident's room. 40798 2. R10's Face Sheet dated 7/29/24 shows she has a status of having a tracheostomy. R10's Order Summary Report dated 7/29/24 shows orders to cleanse tracheostomy site every shift and as needed. On 7/29/24 at 9:33 AM, R10 was noted to have a tracheostomy. R10 said she has had a trach (tracheostomy) for over [AGE] years. There was no signage on R10's door indicating EBP were in place nor was any PPE located outside of R10's room. 3. On 7/29/24 at 9:37 AM, R13 said he sees the wound care doctor every week. There was no signage on R13's door indicating EBP were in place nor was any PPE located outside of R13's room. R13's Admission Record dated 7/30/24 shows R13 has a personal history of methicillin resistant staphylococcus aureus infection. R13's Order Summary Report dated 7/30/24 shows he has an open wounds to his medial upper back, left calf and left foot. 4. On 7/29/24 at 9:56 AM R14 was in her room in her wheelchair with a urinary catheter bag hanging on her wheelchair. There was no signage on R14's door indicating EBP were in place nor was any PPE located outside of R14's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's list of residents on Enhanced Barrier Precautions dated 7/29/24 includes, but is not limited to, R14 for an indwelling catheter, R13 for left lower extremity venous stasis wounds, and R51 for and indwelling catheter. R10 is not included on the list. According to the CDC (Centers for Disease Control and Prevention) website dated 6/28/24 https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html?CDC_AAref_Val=https://www.cdc.gov/hai/containment/faqs.html Signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of Precautions and the recommended PPE to be worn when caring for the resident. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure Precautions are followed. According to the CDC website (updated 7/12/22) https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html, residents with wounds (including a tracheostomy) or urinary catheter are to be placed on EBP, regardless of MDRO colonization status. The facility's Infection Control-Enhanced Barrier Precautions Policy (approved 3/29/24) shows, .the facility will implement Enhanced Barrier Precautions for indicated residents who pose risk of transmission.