

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/11/2025
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)		
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. Based on observation, interview, and record review, the facility failed to ensure the resident refrigerator was kept at a temperature at or below 41 degrees Fahrenheit. This applies to all residents in the building. The findings include: The facility's resident roster provided to surveyors on 9/9/25 showed 70 residents residing in the building. On 9/10/25 at 12:54PM, the resident food and drink refrigerator temperature was 44 degrees Fahrenheit. The refrigerator had many items of food and drink located in it. The facility's log for the resident food and drink refrigerator for September 2025 showed temperatures ranging from 44-48 degrees Fahrenheit from 9/1/25-9/10/25. On 9/10/25 at 1:07PM, V2 (Director of Nursing) stated, I believe night shift nurse's check the refrigerator temperature for the resident refrigerator. It should be below 42 degrees. If it's not, then they should adjust the dial in there and recheck it. V2 then obtained the form located on the front of the refrigerator and noted there are no directions for nurses to know what the acceptable temperature is or what actions to take if the temperature is not in a safe zone. The facility's policy titled, Foods Brought by Family/Visitors dated 3/29/24 showed, 10. All resident refrigerators will have an internal thermometer to monitor for safe food storage temperatures. Units must maintain safe internal temperatures in accordance with state and federal standards. If the temperature is not maintained at 41 degrees Fahrenheit or below, the food will be discarded .		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure hot liquids were served at a safe temperature for all residents residing in the facility, failed to ensure a resident was transferred with a gait belt for 1 resident (R41). The findings include:1) The facility's roster provided to surveyors on 9/9/25 showed 70 residents residing in the building.On 9/9/25 at 12:20PM, V3 (Dietary Manager) showed surveyor the facility coffee and hot water machine. V3 stated, The machine is set to 205 degrees Fahrenheit. That is set by the company that services it.On 9/9/25 at 12:26PM, R34,R45,R54, and R61 all had hot coffee served to them. All residents stated the coffee was too hot to drink and it needed to cool awhile before drinking it. The coffee was observed to be steaming in all 4 resident's mugs.On 9/10/2025 at 7:58AM, V3 obtained the temperatures of the hot coffee and hot water that was poured into the carafes and being taken out to the dining area. The hot coffee temperature was 173 degrees Fahrenheit, and the hot water was 154 degrees Fahrenheit. V3 stated, We don't have a process for hot liquids it just goes right from the machine that is always set at 205 degrees Fahrenheit and it goes straight to the carafe and out to the residents.On 9/10/25 at 8:08AM, The first resident was being served hot coffee. The temperature of the hot coffee was 170 degrees Fahrenheit, and the hot water was 138 degrees Fahrenheit. On 9/10/25 at 1:07PM, V2 (Director of Nursing) stated, I'm not sure if we do hot liquid assessments or what the safe temperature for hot liquids would be. You want it hot enough that it's enjoyable but not hot enough to burn them if they spill it.On 9/10/25 at 1:32PM, V5 (Regional Director of Operations) stated, We have never done hot liquid assessments for our residents. I'm not sure where we would even document that in our system. Our policy for serving hot liquids is 180 degrees or below are safe to serve to residents.The facility's policy titled, Safety of Hot Liquids dated 3/21/25 showed, Residents will be evaluated for safety concerns and potential for injury from hot liquids upon admission, readmission and on change in condition. Appropriate precautions will be implemented to maximize choice of beverages while minimizing the potential for injury .4. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include maintaining hot liquids serving temperature of not more than 180 degrees Fahrenheit .2) R41's electronic face sheet printed on 9/11/25 showed R41 has diagnoses including but not limited to history of falls, type 2 diabetes, chronic kidney disease, depression, and muscle weakness.R41's facility assessment dated [DATE] showed R41 has no cognitive impairment and requires substantial/maximal assist for ambulation.R41's physician's orders dated 5/14/25 showed, 1 assist, gait belt for all transfers.R41's fall risk assessment dated [DATE] showed R41 is a high fall risk.R41's care plan dated 6/3/25 showed, (R41) has limited physical mobility related to weakness, syncope, and assistance required for ambulation .(R41) is able to ambulate with restorative aide, gait belt, and her four wheeled walker.R41's nursing progress notes dated 8/15/25 showed, Patient was ambulating with her walker and tripped and fell. She bumped her back against the walker .Patient states her back is tender where she bumped it IDT (Interdisciplinary Team) reviewed the resident's fall. Root cause of fall determined to be unsteady gait/ambulation; resident being assisted to the toilet without a gait belt when ambulating .On 9/9/2025 at 1:27PM-, R41 stated, It was the middle of the night, and I had a girl come in and help me to the bathroom because I can't go on my own. I lost my balance and I fell towards my back and side area. I was walking with the walker because therapy said I could walk that far with the walker with help. She did not have the belt around me. I don't remember what I was wearing on my feet. I was either barefoot or had the slip-on shoes on. It all happened so fast. I fractured a few ribs. Now that I fell, they make sure they put the belt around me, and I continue to ask for help to get up. Before I came here, I was falling pretty much every week, if not more.The facility Incident Report Investigation dated 8/16/25 showed, On 08/16/25 at 5:35PM, (Local Imaging (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Company) called and faxed results of x-rays reveals subacute fractures of the lateral right 5th,6th and 7th ribs. Subacute is in healing stages, most likely fractures are related to falls prior to admission. Physician was called and faxed results. On 9/10/25 at 11:17AM, V6 (Certified Nursing Assistant) stated, I was transferring (R41) to the bathroom in the night, and she used her walker. I did not have a gait belt on her. She started to fall sideways, and I couldn't grab onto her fast enough and she fell on her bottom and then fell over to her side. I know I should have had the belt on her, but she is usually pretty steady so I didn't think it would be an issue. On 9/10/25 at 1:07PM, V2 (Director of Nursing) stated, Staff should have used a gait belt when transferring (R41) to help keep the resident steady and if they are going to fall then you have something to grab onto to either lower them safely or prevent the fall. The facility's policy titled, Safe Lifting & Movement of Residents dated 3/21/25 showed, In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents .4. Gait belts shall be used on residents unless residents are independent with ambulation, or supervision only, or contraindicated in the resident's care plan.		

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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** Based on observation, interview, and record review the facility failed to prevent cross contamination during incontinence care, thoroughly clean a glucometer and blood pressure wrist cuff after use, and ensure hand hygiene was completed during medication administration for 4 of 4 residents (R73, R1, R60, & R10) reviewed for infection control in the sample of 36. The findings include: 1. On 9/9/2025 at 10:51 AM, V12 Certified Nursing Assistant (CNA) answered R73's call light and stated she needed to get items to change the resident due to being incontinent of urine and stool. At 10:58 AM, V12 CNA, V15 CNA, and V14 CNA came into R73's room to provide care; they all applied gloves. V12 held up a blanket and sheet in front of the resident's groin while V14 provided care. R73 was incontinent of urine and stool. V14 washed R73's groin and penis folding over washcloth as she did it. V14 rinsed and dried R73's groin and penis. R73 stated he needed to use the urinal. V14 did not change her gloves after providing care or wash her hands. V14 went into R73's bathroom, brought his urinal back and gave it to him to use. V14 moved the blanket and sheet back for the resident to use the urinal. V12 took the urinal when he was done. V14 changed gloves. V14 grabbed a wet washcloth and towel and provided perineal care. V14 did not change her gloves. V14 grabbed a clean incontinence brief and laid it on top of the resident's blanket. V14 changed her gloves. R73 was turned onto his left side; he was incontinent of stool. V14 washed, rinsed, and dried his buttocks and anus. V14 did not change her gloves. V14 folded over the incontinence pad and pushed it under the resident. V14 pulled up the side of the incontinence brief and secured it in place. R73 was turned onto his other side. V12 washed and dried R73's left buttock. V12 changed her gloves and secured the incontinence brief in place. V12, V14, and V15 were asked when gloves were to be changed. V14 stated gloves are changed after care. V15 stated gloves were to be changed after being dirty and before touching anything clean. V12, V14, and V15 were asked what they saw during the care provided. V12 stated she saw V14 touch R73's blanket after providing care and she had not changed her gloves. V15 stated V12 provided incontinence care but did not change her gloves before putting the clean incontinence brief on the resident. On 9/10/25 at 2:41 PM, V2 Director of Nursing stated gloves are to be changed when going from dirty to clean and that is for infection control. The Face Sheet dated 9/10/25 for R73 showed diagnoses including right sided hemiplegia, Parkinson's Disease, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, cerebral infarction, type 2 diabetes mellitus, hypokalemia, dysarthria following cerebral infarction, paranoid schizophrenia, muscle weakness, insomnia, pneumonia, paroxysmal atrial fibrillation, dysphagia, and essential hypertension. The Minimum Data Set (MDS) dated [DATE] for R73 showed moderate cognitive impairment; dependent for personal hygiene; substantial/maximal assistance needed for shower/bath; and occasionally incontinent. The Care Plan dated 7/11/25 for R73 showed, Toileting: R73 is incontinent of bowel and bladder. R73 is dependent on staff for peri care, use of the bedpan, changing clothing, and linens as needed. The facility's Perineal Care policy (3/21/25) showed, the purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the residents skin condition. Wash perineal area. Thoroughly rinse perineal area. Dry area thoroughly. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Remove gloves and discard into designated container. Wash and dry hands thoroughly. Reposition the bed covers or clothing. Make the resident comfortable. 2. On 09/10/2025 at 11:23 AM, observed V4 (Licensed Practical Nurse) obtain R1's blood sugar in the resident's room. V4 then returned to her med cart and placed the glucometer in the top drawer of med cart then documented in R1's electronic administration record. At 11:25 AM, when asked by surveyor how and when the glucometer is disinfected, V4 said oh I forgot and after use then removed the glucometer from the top drawer and proceeded to wipe down the glucometer with a cavi wipe (germicide disposable wipe) then placed the glucometer back into the top drawer. (V4 was not observed using this glucometer on any other residents.) R1's face sheet documented an admission date of 08/28/2025 with a past medical history not limited to type 2 diabetes mellitus. R1's active physician orders as of 09/11/2025 provided by facility showed orders to check blood glucose as need for signs and symptoms of hyper/hypoglycemia and to administer insulin lispro per sliding scale based off blood sugar obtained before meals and at bedtime. 3. On 09/10/2025 at 11:33 AM, observed V4 apply gloves to both hands while in R60's room then instilled one drop of refresh tears (carboxymethylcellulose sodium) to each eye. V4 then removed the gloves and threw them in R60's garbage can. V4 returned to the med cart and proceeded to document in R60's electronic administration record. Surveyor did not observe V4 perform any hand hygiene after removing the gloves. At 11:42 AM, V4 said she should have performed hand hygiene after removing her gloves/administering eye drops. R60's face sheet documented an admission date of 02/11/2022 with a past medical history not limited to dementia and hypertension. R60's active physician orders as of 09/11/2025 provided by facility showed orders instill one drop of refresh tears ophthalmic solution in both eyes three times a day for dry eyes. Review of R60's medication administration record on 09/11/2025 showed V4 documented administering R60's eye drops at the 12:00 PM scheduled dose time. 4. On 09/10/2025 at 11:36 AM, V4 said she needed to obtain a blood pressure reading for R10 prior to medication administration. V4 took a blood pressure wrist cuff from the top of med cart and proceeded into R10's room and obtained her blood pressure. V4 returned to the med cart and placed blood pressure wrist cuff on top of cart but did not observe V4 sanitize the cuff. V4 then prepped R10's blood pressure medication and administered the med to R10 at 11:38 AM. At 11:40 AM, V4 indicated that she cleans the cuff between residents with a cavi wipe. Surveyor did not observe V4 sanitize blood pressure wrist cuff during observation. (V4 was not observed using this blood pressure cuff on any other residents.) R10's face sheet documented an admission date of 01/27/2024 with a past medical history not limited to hypotension. On 09/11/2025 at 10:59 AM, V2 (Director of Nursing/Infection Preventionist) said hand hygiene should be performed after administering eye drops, removing gloves and/or in between residents to prevent spreading any infections. V2 added that resident equipment should be wiped down with a cavi wipe and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow contact time per guidelines on back of container. V2 then indicted that V4 should have kept the glucometer and blood pressure cuff wrapped with a cavi wipe for two minutes after use to disinfect, and to prevent transmission of any germs between residents. Medication Administration policy provided by facility that was last reviewed 03/21/2025 reads in part, . staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable . Hand Hygiene policy provided by facility that was last reviewed 03/21/2025 reads in part, proper hand hygiene practices reduce the transmission of pathogenic microorganisms to residents, visitors, and other staff members. All personnel working in the long term care facility are required to wash or sanitize their hands before and after resident contact; . after removing gloves. Application of Eye Medication policy provided by facility that was last reviewed 03/21/2025 reads in part, the purpose of this procedure is to provided guidelines for the instillation of eye ointment or drops to treat eye infections and to soothe of lubricate the eye. steps in procedure included to .put on gloves.administer eye drops as prescribed.remove gloves and discard in designated container. Wash and dry your hands thoroughly. Super Sani-Cloth (germicidal disposable wipe) partial label photo provided by V2 (DON) showed, disinfects in 2 minutes. On 09/12/2025, obtained Sani-Cloth manufacture label guidelines (pdihc.com) to disinfect and deodorize that indicated to unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Let air dry. (see attached manufacturer labels).		

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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. The facility failed to ensure hospice interventions were implemented as ordered for 1 of 1 resident (R6) reviewed for hospice in the sample of 36. The findings include: On 9/9/25 at 9:48 AM, R6 was laying on her left side in bed asleep. R6 had an air mattress in place that was not turned on. The setting on the air mattress was set at 6. V12 Certified Nursing Assistant (CNA) was in the hall and was asked to check R6's air mattress. V12 confirmed the air mattress was not on and stated it should be turned on. V12 stated she did not know what the setting on the air mattress should be and would check with the nurse. On 9/9/25 at 10:34 AM, V10 Licensed Practical Nurse (LPN) stated R6 had the air mattress because hospice recommended it. V10 stated R6 had the air mattress due to her weight; she is small and bony. V10 stated the air mattress is to prevent pressure injury. On 9/9/25 at 10:36 AM, V13 LPN stated she flipped the switch on the air mattress and the green light came on. V13 confirmed the air mattress works; however, it had not been turned on. The Physician Orders for R6 dated September 2025 showed she was admitted to hospice on 8/18/25. The air mattress setting order was obtained on 9/9/25 and stated to set the mattress at 3. On 9/10/2025 at 2:41 PM, V2 Director of Nursing (DON) stated R6 has an air mattress that was provided by hospice because she is frail. V2 stated they called hospice for the settings for the mattress yesterday. On 9/11/2025 at 9:44 AM, V10 LPN stated when someone goes on hospice they deliver the equipment including the mattress that night or the next day. It is usually done quickly. V10 stated she did not know anything about her hospice care plan for R6. On 9/11/25 at 9:53 AM, V10 stated she found out that the hospice notes have categories listed on them and a care plan. The Hospice Note dated 9/3/25 for R6 did not show any information related to the air mattress on her bed or plan of care related to the air mattress. The facility's Care Plan dated 9/7/25 for R6 did not show she was receiving hospice care, R6's care plan was revised on 9/10/25 under the risk for pressure ulcers/skin breakdown focus to show she has a low air loss mattress, but it did not include the setting for the mattress. The Face Sheet dated 9/11/25 for R6 showed diagnoses including dementia, muscle weakness, dysphagia, abnormal posture, osteoarthritis, restlessness, agitation, severe vascular dementia with mood disturbance, unspecified psychosis, hyperlipidemia, hypertension, hypothyroidism, and aortic valve stenosis. On 9/11/25 a policy regarding hospice was requested, no policy available.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete weekly wound assessments for a resident (R5), failed to identify a new pressure ulcer for a resident (R5), failed to develop a pressure ulcer care plan for a resident (R39). These failures apply to 2 of 4 residents reviewed for pressure ulcers in the sample of 36. The findings include: 1) R5's electronic face sheet printed on 9/11/25 showed R5 has diagnoses including but not limited to vascular parkinsonism, dementia without behaviors, anxiety disorder, depression, mood disorder, and anemia. R5's facility assessment dated [DATE] showed R5 has mild cognitive impairment and has one stage 2 pressure ulcer. R5's care plan dated 6/13/25 showed, (R5) has pressure ulcers/skin breakdown related to advanced age resulting in natural thinning and fragility of skin, impaired cognition, unspecified dementia, impaired perfusion to the tissues, chronic kidney disease, need for assistance from staff with ADLs (Activities of Daily Living), and bowel and bladder incontinence resulting in excess moisture exposure to the skin. During a move skin probably slides to some extent against sheets or chairs. (R5) [NAME] maintains relatively good position in chair or bed most of the time but occasionally slides down resulting in friction and shear to skin low pressure air mattress to relieve pressure. R5's skin breakdown risk assessment dated [DATE] showed R5 is at risk for skin breakdown. R5's weekly wound assessment dated [DATE] showed, Right buttock stage 2 improving 20% yellow wound bed, no drainage 0.5cmx0.8cmx0.1cm (centimeters). No weekly wound assessments were present in R5's electronic medical record from 8/6/25-9/11/25. On 9/11/25 at 11:32AM, V13 (Wound Care Nurse) stated, I just started this position on Monday. (R5) has not been seen or had a wound assessment since 8/5/25 by our wound Nurse Practitioner. Wounds should be assessed at least weekly and with any changes. The nurse's are doing their treatments daily so they are looking at them but not doing a full assessment. I would assume they would let someone know if the wound has worsened but I honestly have no idea what it looks like. On 9/11/25 at 1:18PM, V13 performed a wound assessment for R5. R5's pressure ulcer measured 2cmx0.5cm with no drainage and wound bed was pink. During this observation, surveyor identified a new, open pressure ulcer. V13 obtained measurements of 0.5cmx0.5cm with no drainage and stated this would be classified as a stage 1 pressure ulcer. V13 stated she was not notified prior to this assessment of any new skin concerns for R5. On 9/11/25 at 1:32PM, V5 (Regional Director of Operations) stated, We have not been getting the weekly wound assessments done for (R5) but I'm not sure why because everyone else gets seen that needs to. If a wound is open then I believe that is a stage 2, not a stage 1. The facility's policy titled, Skin Conditions-Wound Policy dated 2/7/25 showed, To provide proper monitoring, treatment, and documentation of any resident with skin abnormalities .all caregivers are responsible for preventing, caring for, and providing treatment for skin ulcerations .Assessment protocols .2. Measurements must be completed weekly by the same licensed person when at all possible. 3. At the time a skin issue is discovered it must be measured . (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R39's admission Record (Face Sheet) showed an initial admission date of 3/22/19 with diagnoses to include but not limited to dementia, morbid obesity, and cellulitis. R39's 3/18/25 Nurse Practitioner Wound Care note showed she had a new deep tissue injury to her right heel. The wound note showed, Heels: offload with heel protector or pillow. R39's 9/9/25 Wound Care note showed she had a deep tissue injury to her right heel. The wound note showed, Heels: offload with heel protector or pillow. R39's Care Plan showed no specific care plan for her deep tissue injury, only a pressure ulcer prevention care plan. R39's care plan showed, [R39] has the potential for pressure ulcer development, skin break down, and impairment to skin integrity. The care plan showed no specific intervention to offload her heels only, [R39's] heels will be kept free of pressure as resident allows. Date Initiated: 09/25/2020 and I require Pressure relieving/reducing device on bed/chair. Date Initiated: 03/27/2019. R39's Physician Orders showed no order to offload her heels. On 09/11/2025 at 8:37 AM, V18 Certified Nursing Assistant (CNA) stated she references CNA charting for pressure injury interventions. V18 stated the CNA charting pulls information from the nursing care plan. V18 stated she does offload R39's heels while she is in bed. On 9/11/2025 at 8:41 AM, V8 CNA stated the CNA charting pulls from the nursing care plan, which provides the CNA's with pressure injury interventions such as offloading. V8 stated she does offload R39's heels when she is in bed. On 9/11/2025 at 10:34 AM, V13 Wound Care Nurse stated typical interventions for residents at risk for pressure injuries would be chair cushions, air mattresses, repositioning, and offloading. V13 said offloading a resident heels would be a typical intervention for a resident at risk for pressure injuries to their heels. V13 stated CNAs are made aware of interventions through the care plan. V13 stated, if a resident has a pressure injury, they should have a specific care plan showing the resident has pressure injuries as well as the interventions to address the injuries. V13 stated R39 does not have this type of care plan, she does not have an intervention to offload heels, and she should have both. V13 stated the purpose of these care plan interventions are to promote wound healing. V13 stated R39's heel wound is improving.		

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 09/11/2025
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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain accurate weights for a resident, failed to implement dietician recommendations for a resident. These failures apply to 1 of 1 residents (R44) reviewed for nutrition in the sample of 36. The findings include: R44's electronic face sheet printed on 9/11/25 showed R44 has diagnoses including but not limited to cerebral infarction, peripheral vascular disease, flaccid hemiplegia, and absence of left leg above knee. R44's facility assessment dated [DATE] showed R44 has no cognitive impairment. R44's care plan dated 7/10/25 showed, (R44) is at risk for nutritional problems. RD (Registered Dietician) to evaluate and make diet changes recommendations as needed. On 9/9/25 at 3:13PM, R44 stated he thinks he has had some weight loss but isn't sure how much. R44 stated he gets weighed on a monthly basis. R44's weight log showed, 6/19/25 149.1lbs, 6/22/25 172.3lbs (23.2lb weight gain within 3 days), 7/7/25 150.8lbs (21.5lb weight loss within 15 days). No documentation was present in R44's electronic medical record showing R44 was re-weighed following his 6/22/25 or 7/7/25 weight. R44's RD note dated 8/14/25 showed, Notified by nursing resident triggers for weight loss. Resident continues on a general, regular diet. Insidious/significant weight loss last 30 days. Continue to monitor weekly weights Recommend to add to weekly weights x 4 weeks to monitor. On 9/11/25 at 10:25AM, V21 (Licensed Practical Nurse) stated, All weights and trends are handled by the wound care nurse. I don't see that (R44) is on weekly weights, if he was there would be an order for it. R44's physician's orders for September 2025 showed no orders for R44 to have weekly weights. On 9/11/25 at 11:12AM, V19 (Lead Certified Nursing Assistant) stated, I give the list out of all the weights at the beginning of the month to the aides and the list of weekly weights when they are due. (R44) is not on the list for weekly weights. V19 provided the current list of residents with weekly weights and R44's name was not present. On 9/11/25 at 11:32AM, V13 (Wound Care Nurse) stated, It is my understanding that when the RD makes recommendations, I will take them to the physician and get them approved by the physician and enter the orders and ensure they are implemented. If (R44) does not have an order for weekly weights and they are not being done, then we are not following the RD's recommendations. When the weights are entered into (computer system), it will trigger for significant weight loss or gain, and we should then re-weigh the resident to ensure accurate weights are obtained. On 9/11/25 at 12:05PM, V2 (Director of Nursing) stated, Weights are obtained monthly and as ordered by the physician. When the RD makes recommendations, we should be sending those recommendations to the physician for orders and then entering them into the residents chart. The facility's policy titled, Weight Assessment and Intervention dated 3/21/25 showed, The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. 4. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the Dietician in writing. 3. Interventions will be care planned and implemented where indicated and re-evaluated with next weighing.		