STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265629	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oregon Care Center	501 Monroe Oregon, MO 64473

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance of the risks and benefits of proposed care. When the facility failed to obtain written consent before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for two Residents (Resident #5, and Resident #7) of the 12 sampled residents. The facility census was 46. Review of the facilities Use of Psychotropic Medications policy, dated 5/9/25, showed: Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication in advance of such initiation or increase. 1. Review of Resident #5's Significant Change in Status Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 9/25/25, showed:The resident had a worsening change in behavior since the previous assessment;The resident had disorganized thinking that changed in severity;The resident had a diagnosis of: anxiety, depression, Schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and non-Alzheimer's Dementia.Review of the Resident's Care Plan, revised 9/23/25, showed:The resident was dependent on staff for meeting emotional, intellectual, social, and physical needs;The resident used anti-anxiety medication;The resident was on antipsychotic and antidepressant medication (medications used to treat mental health disorders and depression).Review of the Physician's Order Sheet, dated November 2025 through December 2025, showed:The resident's order for olanzapine 2.5mg (milligram) by mouth at bedtime (an antipsychotic medication) began on 3/5/25;The resident's order for bupropion 75mg by mouth in the morning (an antidepressant medication) began on 3/5/25;The resident's order for venlafaxine 150mg by mouth once a day (an antidepressant medication) began on 4/10/25;The resident's order for venlafaxine 75mg by mouth one time a day began on 4/10/25.Review of the residents medical record on 12/3/25 showed the facility did not have any record of a consent form for the resident regarding the use of psychotropic medications.2. Review of Resident #7's Quarterly MDS, dated [DATE], showed:The resident reentered the facility from an inpatient psychiatric facility;The resident had a diagnosis of: Depression, schizophrenia, and traumatic brain injury.Review of the Resident's care plan, revised 9/17/25, showed:The resident had a communication problem related to a traumatic brain injury;The resident used psychotropic medications related to schizophrenia and depression;The resident was dependent on staff for social, intellectual, emotional, and physical needs.Review of the Physician's Order Sheet, dated November 2025 through December 2025, showed:The resident's order for amitriptyline 100mg by mouth at bedtime (an antidepressant medication) began on 7/12/24;The resident's order for risperidone 2mg by mouth two times a day (an antipsychotic medication) began on 7/12/24;The resident's order for venlafaxine 75mg two capsules one time a day by mouth (an antidepressant medication) began on 11/20/24.Review of the residents medical record on 12/3/25 showed the facility did not have any record of a consent form for the resident regarding the use of psychotropic medications.During an interview on 12/04/2025 at 12:43 P.M. Licensed Practical Nurse (LPN) A said he/she was not sure when or if consents for psychotropic medications needed to be signed by the resident or the resident's responsible party. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/2025 at 12:43 P.M. the Director of Nursing (DON) said consents only need to be signed if a resident is started on a new medication or has a dosage change.During an interview on 12/04/2025 at 12:57 P.M. the DON said She should have interpreted the facilities policy as when the resident is initially admitted to the facility a consent needs to be signed for psychotropic medications. During an interview on 12/04/2025 at 12:57 P.M. the Administrator said she interpreted the policy wrong and consents for psychotropic medications should have been signed for all resident's or by their responsible party when admitted to the facility.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the resident's right to personal privacy and confidentiality of his or her personal and medical records when CMT (Certified Medication Technician) A walked away from the computer on the medication cart leaving confidential resident information open on the computer screen. This affected three (Resident #7, #16, and #32) of 12 sampled residents. The facility census was 46.Review of the Nursing Home Resident Right's policy, undated, showed: -Resident's have a right to privacy regarding personal, financial, and medical affairs;-Resident's have a right to privacy during treatment and care of personal needs. 1. Review of Resident #32's Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 10/19/25, showed:- The resident was taking diuretic (a medication that assists the body with getting rid of excess fluid and salt), hypoglycemic, and antiplatelet (medication that prevents blood clots from forming) medication;- The resident had a diagnosis of: mild cognitive impairment, primary hypertension (abnormally high blood pressure), and Type One Diabetes (a chronic condition where the pancreas does not make insulin). Review of the Resident's care plan, revised 9/11/25, showed:- The resident had an activities of daily living deficit due to limited mobility;- The resident was at risk for falls due to balance problems;- The resident had acute pain due to multiple rib fractures. Observation on 12/03/2025 at 4:10 P.M. showed CMT A left the computer screen on the medication cart open, unlocked, and visible to anyone who walked by the medication cart to view confidential information when he/she walked into the resident #32's room. 2. Review of Residents #16's Quarterly MDS, dated [DATE], showed:- The resident was taking anticoagulant (blood thinning medication) and antiplatelet (medication that prevent blood clots from forming) medications;- The resident had a diagnosis of: visual loss, hypertension, and heart failure. Review of the Resident's care plan, revised 11/11/25, showed:- The resident was dependent on staff for meeting emotional, intellectual, physical, and social needs;- The resident required assistance with activities of daily living due to blindness;- The resident had a communication problem related to a hearing deficit. Observation on 12/03/2025 at 4:25 P.M. showed CMT A left the computer screen on the medication cart open, unlocked, and visible to confidential information when he/she walked into the resident #16's room. 3. Review of Resident #7's Quarterly MDS, dated [DATE], showed:- The resident was taking antipsychotic, antidepressant, and anticoagulant medication;- The resident had a diagnosis of: traumatic brain injury, depression, and hypertension. Review of the Resident's care plan, revised 9/19/25, showed:- The resident was dependent on staff for meeting physical, emotional, and social needs;- The resident had an activity of daily living self-care performance deficit related to paralysis to the left side;- The resident had a communication deficit related to a traumatic brain injury. Observation on 12/03/2025 at 4:27 P.M. showed CMT A left the computer screen on the medication cart open, unlocked, and visible to confidential information when he/she went into the shower room. During an interview on 12/03/2025 at 5:03 P.M. CMT A said he/she knows not to leave the computer screen open with resident information visible when passing medications and should have closed the computer screen. During an interview on 12/04/2025 at 12:43 P.M. LPN A said the computer screen is not supposed to be left open when walking away from the medication cart, it either needs to be locked or on privacy mode. During an interview on 12/04/2025 at 12:57 P.M. the Director of Nursing (DON) said staff are not to leave the computer screen open with resident information visible when walking away from the medication cart. During an interview on 12/04/2025 at 12:57 P.M. the Administrator said she tells staff to minimize the computer screen or shut the laptop before walking away from the medication cart, it should not be left unattended.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to provide a safe, comfortable and homelike environment. This affected all residents. The facility census was 46. Review of the facility's Safe and Homelike Environment Policy, dated 6/15/25 showed:-The facility will provide a safe, clean, comfortable and homelike environment;-Environment refers to any place in the facility that is frequented by residents, including dining areas and hallways.Review of the facility's Resident Environmental Quality Policy, dated 6/15/25 showed:-The facility shall be equipped and maintained to provide a safe, functional, and comfortable environment for the residents;-The facility will provide maintenance of the building to maintain a safe and homelike environment.Review of the facility's Handrails Policy, dated 6/15/25 showed routine maintenance on handrails will be completed by the maintenance department.Observation of the facility on 12/03/25 at 10:10 A.M., showed:-The base board heater between room [ROOM NUMBER] and room [ROOM NUMBER] was dented, bent out of shape and protruded into the hallway;-The base board heater between room [ROOM NUMBER] and 213 was dented, bent out of shape and protruded into the hallway;-The handrail on the right side of the hall outside the dining room was chipped and splintered when touched;- A piece of drywall was missing in the hall between room [ROOM NUMBER] and room [ROOM NUMBER];-The handrail between room [ROOM NUMBER] and 207 had missing paint and splintered when touched;-The handrail on the left side of the fire doors had missing paint and splintered when touched.During an interview on 12/03/25 at 12:58 P.M., the Maintenance Supervisor said:-He is responsible for the repairs to the walls, handrails and baseboard heaters in the facility;-All areas of the building should be in good repair;-He had not had time to complete the needed repairs.During an interview on 12/03/25 at 1:17 P.M., the Administrator said;-She expected all areas of the building to be in good repair;-She expected the maintenance department to complete these repairs.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain the resident's highest practicable level of physical, mental and psychosocial well-being that prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist for three residents (Resident #5, #24, and #19) of the 12 sampled residents, when the facility to complete and follow the recommendations for a medication review. The facility census was 46.The facility did not provide the requested policy regarding Drug Regimen Reviews. Review of the facility's Gradual Dose Reduction of Psychotropic Drugs policy dated 6/6/25 showed that residents who use psychotropic drugs will receive gradual dose reductions unless clinically contraindicated. 1. Review of Resident #24's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 11/15/25 showed:-Severe cognitive impairment;-Antipsychotics administered to the resident;-Diagnoses included dementia and heart failure. Review of the resident's care plan dated 11/15/25 showed:-Impaired cognitive function related to dementia;-The resident received Seroquel (used to treat mental health conditions) for dementia. Review of the resident's medical record showed:- Physicians Order Sheet (POS) dated, 12/31/25 with an order for Seroquel 100 milligrams (mg) before bed with a start date of 9/19/25 with no diagnosis for use;-Review of the residents Medication Administration record dated (MAR), 12/31/25 with an order for Seroquel 100 mg give before bed, with no diagnosis for its use;-Consultant pharmacist recommendation dated 10/18/25 that showed the resident was receiving the antipsychotic agent Seroquel but lacked an allowable diagnosis to support its use;-No record that the physician had addressed the pharmacy recondensation was found. 2.Review of Resident #19's Quarterly MDS dated [DATE] showed:-No cognitive impairment;-Anticonvulsant medication administered;-Diagnoses included, seizure disorder, diabetes and depression. Review of the resident's care plan dated 9/15/25 showed:-The resident took medication for seizure disorder;-Obtain labs per physician's order and notify the physician of results. Review of the resident's medical record showed:-POS dated 12/31/25 with an order for Keppra (used to treat seizures) 750 mg two times daily;-The resident's MAR dated 12/31/25 with an order for Keppra 750 mg two times daily;-Pharmacy recommendation sheet dated 10/28/25 showed lab work is ordered but cannot be located in the medical record for a Keppra level on the next lab day and every three months;-No record that the physician had addressed the pharmacy recommendation was found;-No lab order for the Keppra level to be drawn was found;-No lab results for the Keppra level were found. 3. Review of Resident #5's Significant Change in Status Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 9/25/25, showed: The resident had impaired cognition and decision making; (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident had difficulty focusing during assessment that fluctuated; The resident had a diagnosis of non-Alzheimer's Dementia, anxiety, depression, and schizophrenia. Review of the Resident's care plan, revised 9/23/25, showed: The resident was dependent on staff for meeting physical, social, emotional, and intellectual needs; The resident used anti-anxiety medication; The resident used antipsychotic and antidepressant medication. Review of the Resident's Physician Order Sheet, dated November 2025 through December 2025, showed the resident's order for venlafaxine 75mg by mouth once a day began on 4/10/25 and the resident's order for venlafaxine 150mg by mouth once a day began on 4/10/25. Review of the Resident's Medication Regimen Review, dated 10/28/25, showed: The resident had been taking venlafaxine 225milligrams (mg) (150mg + 75mg) once daily since (an antidepressant medication) 4/10/24 without a gradual dose reduction; The pharmacist recommended an attempt of a gradual dose reduction to determine if the resident was on the lowest possible dose; The pharmacist requested a response with a reason why if the gradual dose reduction was not able to be completed; Did not show any documentation the information was sent to the physician or if the physician responded. During an interview on 12/3/25 at 9:18 A.M., the Director of Nursing (DON) said:-She is responsible for completing the pharmacy recommendations and getting them to the physician;-The recommendations should have been reviewed by the physician within 48 hours and any new orders followed;-Gradual dose reductions should be completed on residents who take psychotropic drugs unless it is contraindicated. During an interview on 12/3/25 at 10:09 A.M., the Administrator said:-Medication regimen reviews should be completed every month on all residents;-She expected the DON to ensure medication regime reviews were being completed ;-She expected the DON to ensure pharmacy recommendations to be addressed within 48 hours by the physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to prepare and serve food in accordance with professional standards of food service when the facility failed ensure the kitchen and dining room were in good repair. The facility census was 46.The facility did not provide the requested policy on repairs of the kitchen and dining room. 1.Observation on 12/02/25 at 12:23 P.M., showed:-A black substance on the wall behind sink in the dish area;-Five broken tiles and two missing tiles under the dishwasher;-The exit door leading into the dining room by the steam table with black stains along the edges and a black area around the door knob; -The doors to the dry storage with a brown substance and black stains on the bottom of the doors;-Seven broken floor tiles under and around the steam table;Observation of the dining room on 12/2/25 at 12:55 P.M., showed:-The cabinet under the sink in the dining room with missing paint and damaged wood on the bottom of it;-Black rings the size of basket balls on two ceiling tiles by the exit door;-Window blinds on all windows broken;-Eight dining room chairs with ripped seats and foam exposed.2.Review of Resident #13's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 9/03/25 showed:-The resident had no cognitive impairment;-Supervision with Activities of Daily Living (ADL)s;-Diagnoses included, diabetes, high blood pressure and anemia.Review of the resident's care plan dated 10/12/25 showed the resident required supervision with ADLs.During an interview on 12/3/25 at 1:45 P.M., Resident #13 said:-The broken chair's are uncomfortable to set in;-It would be nice to have blinds that are not broken to look at during meals.During an interview on 12/03/25 at 1:45 P.M., the Maintenance Supervisor said:-He is responsible for the repairs in the kitchen and dining room;-He said the kitchen and dining room should be in good repair;-He said the dining room chairs needed to be replaced because they were torn and uncomfortable;-He said he was trying to get the repairs completed but had not had time.During an interview the Administrator said:-She expected the kitchen and dinging room to be in good repair;-She expected the dinging room furniture to be in good repair and comfortable;-She expected the window blinds to be in good repair and clean;-The Maintenance supervisor is responsible for repairs to the kitchen and ding room.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a reassessment of the Level I preadmission screening resident review (PASARR) assessment (used to identify individuals with mental illness or intellectual/developmental disabilities completed before admission to the nursing facility and when a resident had a new diagnosis of a mental illness) for one (Resident #5) of the 12 sampled residents, when the resident had a new diagnosis of a serious mental illness. The facility census was 46. Review of the facilities Resident Assessment- Coordination with PASARR Program policy, dated 6/30/25, showed: Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. A negative Level I Screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. 1. Review of Resident #5's Significant Change Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 9/25/25, showed:- The resident had disorganized thinking;- The resident had difficulty focusing attention;- The resident had a diagnosis of: Non-Alzheimer's Dementia, anxiety, depression, and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, and emotional responsiveness). Review of the Resident's care plan, revised 9/17/25, showed:- The resident was dependent on staff for meeting physical, social, and emotional needs;- The resident used psychotropic medications related to mood disorder, schizoaffective disorder, and major depressive disorder;- The resident used anti-anxiety medications. Review of Resident #5's admission MDS, dated [DATE], showed: The resident did not have a diagnosis of schizophrenia at the time the admission MDS was completed. Review of the Resident's Level I PASARR, dated 8/19/21, showed: - The resident did not show any signs or symptoms of a major mental disorder;- The resident was not diagnosed as having a major mental disorder;- The resident did not qualify for a Level II Screening. Review of the resident's current Diagnosis Report, dated 12/4/25, showed: The resident had a diagnosis of schizoaffective disorder with an onset date on 3/28/25. During an interview on 12/04/2025 at 12:57 P.M. the Administrator said:- Resident #5 had a diagnosis of schizoaffective disorder since he/she was admitted when the initial level I PASARR was completed;- Some resident information did not transfer over in the charting system when the new company took over. - A new PASARR should have been completed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls when the facility failed to ensure that three bottles of lorazepam, a schedule IV medication (a controlled medication used to treat mood and behavior), was secured behind two locks. The facility census was 46. Review of the facilities Medication Storage policy, dated 5/9/25, showed: Schedule II drugs and back-up stock of schedule III, IV, and V medications are stored under double-lock and key. Observation of the medication room on 12/02/2025 at 4:17 P.M. showed:- Medication refrigerator that contained three bottles of liquid lorazepam was not locked;-The lock for the medication fridge was sitting on a counter in the medication room;- A piece of the locking mechanism on the fridge in the medication room was not attached to the fridge. During an interview on 12/02/2025 at 4:17 P.M. Certified Medication Technician (CMT) B said the lock for the fridge had been broken for awhile, not sure how long. During an interview on 12/02/2025 at 4:25 P.M. the Administrator said she was not aware that the lock for the fridge in the medication room was broken. During an interview on 12/02/2025 at 4:30 P.M. the Administrator said a piece of the locking mechanism was not attached to the fridge so the lock would not work. During an interview on 12/03/2025 at 5:03 P.M. CMT A said he/she did not know the lock on the fridge in the medication room was broken. During an interview on 12/04/2025 at 12:28 P.M. CMT C said he/she had heard that the lock was broken on the fridge in the medication room. During an interview on 12/04/2025 at 12:43 P.M. Licensed Practical Nurse (LPN) A said he/she was not sure how long the lock on the fridge in the medication room had been broken.