

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Doctors Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Hawthorn Road Salem, IL 62881	

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 0584 Level of Harm - 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. (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 0584 Level of Harm - Actual harm Residents Affected - Some	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide Heat, Ventilation, and Air Conditioning (HVAC) systems to maintain a comfortable temperature and failed to maintain flooring that was clean and free from damage. This failure resulted in R1 and R6 experiencing difficulty breathing and R5 and R7 experiencing difficulty sleeping, resulting in significant discomfort. This failure has the potential to affect all 58 residents residing in the facility. Findings include: 1. On 7/30/25 at 10:03 AM, a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit. R1's Resident Face Sheet documented an admission date of 12/12/24 and included diagnoses of morbid obesity, chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease, and congestive heart failure. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating R1 was cognitively intact. On 7/30/25 at 10:33 AM, R1 was sitting on the side of her bed in her room wearing an oxygen nasal cannula connected to an oxygen condenser set at 3 liters per minute. The thermometer measured the ambient air temperature of R1's room to be 85.6 degrees Fahrenheit (F). R1's Packaged Terminal Air Conditioner (PTAC) unit was on but was not blowing out cold air. R1 said it was so hot in her room she was having difficulty sleeping. R1 stated we just sleep covered in sweat. R1 said due to the heat she was having increased difficulty breathing. R1 stated I'm on oxygen with COPD (Chronic Obstructive Pulmonary Disease). I can't hardly breathe with this heat. I'm struggling. R6's Resident Face Sheet documented an admission date of 1/30/23 and included diagnoses of morbid obesity, chronic obstructive pulmonary disease, and chronic respiratory disease. R6's MDS dated [DATE] documented a BIMS score of 14, indicating R6 was cognitively intact. On 7/30/25 at 10:59 AM, R6 was sitting in the dining room in her wheelchair wearing an oxygen nasal cannula connected to an oxygen concentrator set at 2 liters per minute. R6 stated It's so hot in here, and it has been like this for weeks. The heat makes it hard for me to breathe in here. The thermometer measured the ambient air temperature of the dining room to be 82.3 degrees F. Several residents were sitting in the dining room participating in a dice game activity and all said they were hot and uncomfortable. R5's Resident Face Sheet documented an admission date of 2/4/25 and included diagnoses of morbid obesity, hypertension, and edema. R5's MDS dated [DATE] documented a BIMS score of 14, indicating R5 was cognitively intact. On 7/30/25 at 10:40 AM, R5 stated it has been so hot in here for the past 3 to 4 weeks since the air conditioning stopped working. It's hard to sleep when it's this hot. I toss and turn all night sweating. This morning trying to get dressed I was already wet with sweat before I could get my clothes on. The thermometer measured the ambient air temperature in R5's room to be 83.6 degrees F. On 7/30/25 at 11:55 AM, the thermometer measured the ambient air temperature of R5's room at 86.1 degrees F. R7's Resident Face Sheet documented an admission date of 7/10/25 and included diagnoses of pneumonia, atrial fibrillation, and insomnia. R7's MDS dated [DATE] documented a BIMS score of 13, indicating R7 was cognitively intact. On 7/30/25 at 10:52 AM, R7 stated It's plenty hot in here. The main problem is it's hard to sleep at night. It's uncomfortable day and night. The thermometer measured the ambient air temperature in R7's room to be 82.6 degrees F. On 7/30/25 at 11:43 AM, staff were passing noon time meal trays to several residents sitting in the dining room. The thermometer measured the ambient air temperature of the dining room to be 84.5 degrees F. On 7/30/25 at 11:49 AM, the Heating, Ventilation, and Air Conditioning (HVAC) unit farthest from the nurse's station on 300 hall was running but putting out a very small amount of cold air and was dripping condensation onto the floor and had ceiling tiles with greenish brown discoloration surrounding it. On 7/30/25 at 11:51 AM, the HVAC unit closest to the nurse's station on 300 hall was not working. On 7/30/25 at 11:53 AM, the HVAC unit above the nurse's station was not working and had 7 ceiling tiles with greenish brown discoloration. On 7/30/25 at 11:56 AM, the HVAC unit closest to the nurse's station on 200 hall was blowing out a small amount of cold air. On 7/30/25 at 11:57 AM, the HVAC unit farthest from the nurse's station on 200 hall was blowing out a small amount of cold air. On 7/30/25 at 11:59 AM, the HVAC unit closest to the nurse's station on 400 hall was not working. On 7/30/25 at 12:01 PM, the HVAC unit farthest from the nurse's station on 400 hall was blowing out a small amount of cold air. On 7/30/25 at 12:06 PM, V4 (Maintenance Director) said he had asked corporate for 33 PTAC units to replace the older PTAC units in resident rooms and corporate had only sent him 4 PTAC units. V4 said several of the PTAC units in resident rooms had been replaced during the winter of 2024 but the PTAC units</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a temperature of less than 70 degrees Fahrenheit in the dietary dry storage area in accordance with facility policy. This failure has the potential to affect all 58 residents residing in the facility. Findings include: On 7/30/25 at 10:03 AM, a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit. On 7/30/25 at 11:08 AM, V5 (Dietary Manager) said the dietary dry storage area did not have a functioning Heating, Ventilation, and Air Conditioning (HVAC) unit and had been very hot since the start of summer 2025. Using the calibrated thermometer, the ambient air temperature in the dietary dry storage area was observed to be 90.6 degrees Fahrenheit. On 7/30/25 at 12:06 PM, V4 (Maintenance Director) said he had notified the HVAC company of the HVAC system not functioning in the dietary dry storage area and was told the HVAC company would not be coming to the facility until the facility paid the bill for the last time the HVAC company had performed work for the facility in December 2024. On 8/1/25 at 2:26 PM, V1 (Former Administrator) said he had been asking corporate to fix the HVAC system in the dietary dry storage area for 1 year and 1 month. The facility's January 2012 Dry Storage Areas policy documented in part . Dry storage areas will be kept neat, orderly, and in a condition which protects foods in a safe and sanitary manner. 1. Non-perishable foods will be stored in a dry area with temperatures that do not exceed 70 F. The facility's 7/30/25 Daily Census Report documented 58 residents residing in the facility.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on interview, and record review the facility failed to ensure the facility was administered and operated in a manner to ensure the safety and overall wellbeing for all 58 residents residing in the facility. Findings include: On 8/1/25 at 2:26 PM, V1 (Former Administrator) said he had emailed and called corporate several times about the HVAC (Heating, ventilation, and Air Conditioning) units and PTAC (Packaged Terminal Air Conditioner) systems not working but didn't hear anything back from them. V1 said he did not have the authority to change the HVAC units, that was a corporate decision. V1 said he had been asking corporate to fix the HVAC unit in the dietary dry storage area for 1 year and 1 month prior to this investigation. V1 said he had notified corporate of the dining room floors needing to be replaced but had not been given approval to fix them. On 7/30/25 at 12:06 PM, V4 (Maintenance Director) said he had been told by the HVAC company they would not return to the facility to fix the HVAC units until their bill had been paid from December 2024. V4 said he had requested from corporate 33 PTAC units for resident rooms and had only been sent 4 PTAC units. V4 said he was aware there was a room where residents residing that did not have a functioning call light system. V4 said he had called the company that fixes the call lights and had been told the company would not come to the facility until their bill was paid. On 8/6/25 at 11:16 AM, V12 (Regional Director of Operations) said corporate was not aware of any of these issues. The facility's 7/30/25 Daily Census Report documented 58 residents residing in the facility.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a functioning call light system for 3 (R2, R3, and R4) of 6 residents reviewed for resident call system in the sample of 6. Findings include: R2's Resident Face Sheet documented an admission date of 2/21/18 and included diagnoses of hemiplegia following cerebral infarction, vascular dementia, and need for assistance with personal care. R2's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. R3's Resident Face Sheet documented an admission date of 8/23/24 and included diagnoses of chronic respiratory failure and history of cerebral infarction. R3's MDS dated [DATE] documented a BIMS score of 9, indicating moderate cognitive impairment. R4's Resident Face Sheet documented an admission date of 12/21/23 and included diagnoses of other motor neuron disease, respiratory failure, and chronic pain. R4's MDS dated [DATE] documented a BIMS score of 15, indicating R4 was cognitively intact. On 7/30/25 at 10:20 AM, there were large, loud industrial fans running at both ends of the hall where R2, R3, and R4's reside. On 7/30/25 at 11:08 AM, R2, R3, and R4 were in the same shared room and had hand bells on their over bed tables. R4 stated that R2, R3, and R4 had the hand bells because the call light was not working in their room. R4 said her call light had stopped working about a week prior to this investigation. R3 said her call light had not been working for a couple months prior to this investigation but was unsure of the exact date it stopped working. R3 said she had been told the facility was waiting on parts to fix it. R4 said up until her call light stopped working, she would use her call light if R3 needed something. R2, R3, and R4's call lights were tested and none were noted to be working. On 7/30/25 at 12:06 PM, V4 (Maintenance Director) said he was aware R2, R3, and R4's call lights were not working. V4 said he had called the company that fixed the facility's call lights and was told they would not come to the facility due to the facility not paying their bill. On 7/30/25 at 12:12 PM, V1 (Former Administrator) said he was not aware the call light company was not coming to fix R2, R3, and R4's call light due to the bill not being paid, and would contact corporate for direction. On 8/6/25 at 10:32 AM, R4 said when the facility has the industrial fans running, R4 has to ring her hand bell for long periods of time because she assumed staff could not hear her bell over the fans. On 8/6/25 at 11:40 AM, V6 (Licensed Practical Nurse/LPN) said when the industrial fans were running, they were so loud staff could barely hear the phone ringing and if staff were down the hall away from R2, R3, and R4's room, staff would not be able to hear their hand bells ringing. On 8/7/25 at 1:20 PM, V7 (Certified Nursing Assistant/CNA) said when the industrial fans were running, there was no way staff could hear R2, R3, and R4's hand bells if staff were down the hall or at the nurse's station. On 8/1/25 at 10:14 AM, V8 (Family Member/Power of Attorney/POA) said she was not sure when R2's call light had stopped working. V8 said she comes to the facility to visit R2 every Sunday and on 7/27/25, V8 saw a hand bell sitting on R2's bedside table. V8 said she had questioned why R2 had a hand bell and was told by staff R2's call light was not working. V8 said the facility was having trouble with their air conditioning and had large industrial fans running. V8 said when the industrial fans were running staff could not hear R2's hand bell ringing. The facility's July 2014 Answering the Call Light policy documented in part .7. Report all defective call lights to the nursing supervisor promptly. On 8/12/25 at 8:52 AM, V9 (Administrator) said she had asked corporate for a functionality of the call light policy and what to do if it wasn't working on 8/8/25 but was told they could not find one.</p>		