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 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Doctors Nursing & Rehab Center	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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician's orders and monitor resident's declining conditions for 2 of 3 residents (R1 and R3) reviewed for resident death in a sample of 8. A. This failure resulted in worsening of R1's infection of bilateral lower leg venous wounds causing sepsis and subsequent death. B. This failure resulted in exacerbation of R3's congestive heart failure resulting in hospitalization and subsequent death. This failure resulted in an Immediate jeopardy, which was identified to have begun on:A. [DATE] when the facility failed to follow physician's orders for antibiotics for R1's infection of venous stasis ulcers. This failure resulted in R1 developing sepsis leading to R1's death on [DATE].B. [DATE] when the facility failed to complete ordered lab work and administer medications as ordered for R3. This failure resulted in worsening of R3's Congestive Heart Failure causing respiratory failure leading to R3's death on [DATE]. V1, Administrator, V2, Director of Nurses, and V30, Regional Director of Operations were notified of the Immediate Jeopardy on [DATE] at 12:25PM. The immediacy for both examples were removed on [DATE], but non-compliance remained at a Level Two because additional time is needed to evaluate the implementation and effectiveness of In-service training. Findings include:1. R1's Face Sheet documents an admission date of [DATE] and a discharge date of [DATE] with diagnoses including in part lymphedema, toxic encephalopathy, cellulitis of right lower limb, cellulitis of left lower limb, methicillin resistant staphylococcus aureus infection, pseudomonas, muscle weakness, severe sepsis with septic shock, type 2 diabetes mellitus with diabetic neuropathy, localized edema, long term use of insulin, and urinary tract infection. R1's Minimum Date Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 15, indicating R1's cognition was intact. In the same MDS it documents under Section I that R1 had an active diagnosis in the last 7 days of wound infection. Section M in the same MDS documents R1 had venous and arterial ulcers. R1's Care Plan documents R1 has a diagnosis of sepsis and history of wounds to bilateral lower extremities related to edema and a history or cellulitis, lymphedema, and current wounds with approach's dated [DATE] documenting treatment as ordered and dated [DATE] documenting medications and antibiotics per order. The same Care Plan documents R1 has a history of infection of the wounds with approach's dated [DATE] documenting R1 is to get antibiotics as ordered and to report to the physician if ineffective or any adverse effects and [DATE] documenting R1 is to have treatments per order. R1's Physician's Orders provided by the consulting wound clinic dated [DATE] documents an order for Vancomycin 1gram (gm) intravenous piggyback to be given twice a day for 14 days. Written to the side of that order is an unsigned note documenting we don't do BID (twice a day) IV (intravenous) notified (V3, consulting wound doctor). R1's Progress Note dated [DATE] at 10:58 AM, documents V13 (RN) notified V3's office that the facility would not be able to do the vancomycin order because they do not do IV medications every 12 hours because they don't have Registered Nurses (RN) on night shift to give the IV antibiotic and V3's office stated they would inform V3 that they don't (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

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 02/10/2026

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	have RN's on night shift to do IV antibiotics and would see what V3 wanted to do. R1's Progress Note dated [DATE] at 3:00 PM, authored by V13, documents V3 ordered the vancomycin order to be changed to vancomycin 1 gm, once a day for 14 days. R1's Progress Note dated [DATE] at 5:08 AM by V28 (LPN) documents a new order was received to increase IV vancomycin from 1gm to 1.5 gm once a day. R1's Medication Administration Record (MAR) dated [DATE] to [DATE] documents an order for Vancomycin in 0.9 % sodium chl (chloride) solution; 1 gram/250 mL (milliliters); Amount to Administer: 1 gm; intravenous once a day with a start date of [DATE] and an end date of [DATE]. This is documented as not administered on [DATE] with a corresponding note of Not Administered: Resident Unavailable and not administered on [DATE], [DATE], [DATE], and [DATE] with a note of Not Administered: On Hold. R1's MAR dated [DATE] to [DATE] documents the same Vancomycin order and documents the order is on hold on [DATE] at 5:00PM. The same Vancomycin order is documented with a start date of [DATE] and an end date of [DATE] and documents that the order was on hold from [DATE] until [DATE] at 4:00PM. The same MAR documents an order for vancomycin in 0.9 % sodium chl solution; 1.5 gram/500 mL;Amount to Administer: 1.5g; intravenous once a day with a start date of [DATE] and an end date of [DATE]. R1's Physician Orders provided by the consulting wound clinic dated [DATE] documents start Bumex 2.5 milligram (mg) once a day by mouth to be given with furosemide dose, Levaquin 750 mg once a day for 14 days, and Cipro 500 mg twice a day for 14 days. R1's MAR dated [DATE] to [DATE] does not document any orders for Bumex, Levaquin, or Cipro. R1's POS dated [DATE]-[DATE] was reviewed, and it does not document any orders for Bumex, Levaquin, or Cipro. R1's Progress Note dated [DATE] at 10:30 PM documents CNA (Certified Nursing Assistant) notified signee earlier in evening of res (R1) BLE (Bilateral Lower Extremities) having increased weeping through drsgs (dressing), explained that puddle in front of res (R1) while sitting in recliner from the weeping. CNA cleaned floor & laid down bath blanket to manage weeping until signee could perform tx (treatment). Upon entering res (R1) room, bath blanket almost completely saturated w (with) weeping from BLE after CNA had just laid down approx (approximately) 1.5 hrs (hours) prior. Res (R1) crying in pain, BLE drsgs completely saturated but intact. Admin (administered) meds (medications)-including PRN (as needed) norco. Signee then performed tx as ordered. Res (R1) continued to cry in pain while attempting to perform txs. Signee req (requested) other noc (night) shift nurse to administer prn morphine IM (intramuscular) dose. Txs finished, res (R1) tolerated better after MS (morphine) admin. BLE remain extremely red w mod (moderate) bleeding to some areas, purulent drainage noted to gauze when cleaned. Area to L (left) ankle/lower shin noted to have greenish drainage & res (R1) c/o (complained of) increased pain to specific area. RLE (right lower extremity) xeroform left in place due to skin graft started, dark black/green noted to xeroform. Mod bleeding & purulent drainage contin [sic] to areas around xeroform. Signee notified DON (Director of Nursing) of consistent worsening of BLE & worsening pain as well. Res (R1) has (Consult wound clinic name) app (appointment) this a.m. Awaiting potential N.Os (new orders). R1's physician order provided by the consulting wound clinic dated [DATE] documents Levofloxacin 750 mg once a day for 10 days and Medrol pak 4 mg oral tablets for 6 days, take 6 tabs on day 1, 5 tabs on day 2, 4 tabs on day 3, 3 tabs on day 4, 2 tabs on day 5, and 1 tab on day 6. R1's Progress Note dated [DATE] at 1:12 AM documents a new treatment order for R1's bilateral lower extremities was received via fax from V3's office. New order to change dressings to bilateral lower extremities daily and as needed. Left lower extremity: cover wound with Dakins solution-soaked gauze wet to dry dressing, cover with abdominal pad and rolled gauze then wrap with Ace bandage from foot to knee with graduated compression. Right lower extremity: leave xeroform in place to protect amniotic graft, apply abdominal pad over wound areas, cover with rolled gauze, then apply ace wraps from foot to knee with graduated compression. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Treatment orders per V3 were placed into R1's electronic chart. New order for antibiotics and steroid dose pak related to bilateral lower extremity wounds received as well, levofloxacin 750 mg by mouth daily for 10 days, signee aware of resident allergy to ordered medication and unsure if R1 has taken medication in the past. A fax was sent to V3's office requesting clarification on the order due to R1's allergy, awaiting reply. Author notified dayshift nurse of possibly needing to call for new orders. Medrol dose pak was placed into R1's electronic chart. R1's Progress Note dated [DATE] at 5:49 AM by V10 (RN) documents V3's office ordered Levofloxacin for R1's lower extremity wounds and they have not replied to the fax regarding R1 being allergic to the medication. V3's office needs to clarify the antibiotic order at R1's appointment. R1's MAR for [DATE] to [DATE] and MAR for [DATE] to [DATE] did not document an order for the Levofloxacin ordered on [DATE]. R1's POS dated [DATE]-[DATE] did not document an order for the Levofloxacin that was ordered on [DATE]. R1's Physician's Orders provided by the consulting wound clinic documents an order dated [DATE] to Start Invanz 1 gram once daily for 14 days for ESBL (Extended Spectrum Beta Lactamase Producing Bacteria) in the urine. R1's MAR dated [DATE] to [DATE] did not document an order for invanz as ordered by V3 on [DATE]. R1's POS dated [DATE]-[DATE] did not document an order for invanz that was ordered on [DATE]. R1's Progress Noted date [DATE] at 5:44 PM by V6 (RN) documents received new orders from (Consultant wound clinic name) to change dressings to bilat (bilateral) lower extremities with gauze soaked with Dakins quarter strength solution. then cover with gauze and abd (abdominal) pads. then wrap legs with kerlix and ace bandages. Change dressings daily. also ordered to remove foley catheter x 1 (for 1) week and start Invanz 1 gram for 1 week r/t (related to) UTI (urinary tract infection) ESBL (Extended Spectrum Beta Lactamase Producing Bacteria) of the urine. They are faxing prescription to (pharmacy name). On [DATE] at 9:50 AM, V6 stated she doesn't remember R1 taking Levofloxacin or Invanz, but she remembers her taking Medrol dose pack. V6 stated she remembers seeing order sheets for R1 that were sent from (consulting wound clinic) but she doesn't know where they came from. V6 stated she worked night shift on [DATE] and she charted a note about the order for Invanz for R1, but she did it for the day shift nurse but doesn't remember who it was, and she doesn't know where they got it from, stated it was written down on a piece of paper. V6 stated she called the pharmacy to see if they had received R1's Invanz order yet and they hadn't so she was going to see if it came in the next night, and it didn't. V6 stated she wasn't following it anymore after that and she doesn't know who was supposed to follow up on it, but she did not follow up on it. V6 stated she said something to the Assistant Director of Nursing (ADON) about it and she thought she was going to take care of it. R1's Progress Notes dated [DATE] at 1:23 PM by V15 (RN) documents Called Pharmacy and spoke with (name) re: (regarding) Invanz order and that (consulting wound clinic) was supposed to fax over order for it. (Name) states they rec'd (received) no order for medication. R1's Progress Note dated [DATE] at 2:12 AM by V10 (RN) documents foley catheter removed tonight x 1 week r/t (related to) ESBL (Extended Spectrum Beta Lactamase Producing Bacteria). Will monitor for output/any issues. Need to clarify abx (antibiotics) order with (consulting wound clinic name) Monday r/t receiving no orders/pharmacy unaware of any new orders. Res (resident) resting quietly in bed at this time. Call light within reach. R1's Progress Note dated [DATE] at 1:00 AM by V10 documents foley (urinary) catheter remains out r/t ESBL of urine. Call (consulting wound clinic name) later today to clarify foley (urinary catheter) is supposed to be out for 1 week & also clarify abx order. Res not c/o (complaining of) any difficulties voiding, no dysuria (painful urination). PRN (as needed) morphine injection admin (administered) tonight prior to BLE tx (treatment). Res (R1) grimacing & holding on to the chair while changing BLE drsgs. Reordered morphine r/t used the rest of vial. Res (R1) now resting in bed. Will continue to (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitor needs & safety. Call light within reach at this time. R1's Progress note dated [DATE] at 12:33 AM by V15 documents Still awaiting ABT (antibiotic) order to be clarified. Dressings d/I (dry and intact) at this time. Foley remains out@ (at) this time, voiding w/o (without) difficulty. Pain meds cont (continue) as ordered. R1's Progress Note dated [DATE] at 9:11 AM by V2 (Assistant Director of Nursing) documents Resident (R1) out of facility to appointment at (consulting wound clinic), this facility transport to appointment, Dressing changes to be done at appointment today. R1's Progress Note dated [DATE] at 9:41 AM by V11 (Licensed Practical Nurse/LPN) documents Spoke to (consulting wound clinic) in (town) aware we have not received atb (antibiotic) order spoke with (name) and will send script to us today provided fax number. Called (pharmacy) related need Norco refilled spoke with (name) and will send out medication. Next apt (appointment) in (town) at 10 am tomo (tomorrow) transportation aware of apt. Resident (R1) aware of all and questions asnswered [sic]. On [DATE] at 1:41 PM, V11 stated she called the consulting wound clinic for R1 on [DATE] at 9:41 AM and told them they didn't have the order for Invanz for R1 and they told her they would fax it that day. V11 stated she doesn't remember if she followed up on it or who she passed the follow up along to, stated she didn't chart anything else so she must have not done anything else with it. R1's Physician Order Report dated [DATE]-[DATE] documents treatment orders as follows; change dressings to bilateral lower extremities daily and as needed, cover with Dakin's solution soaked gauze wet to dry dressing, cover with abdominal pads, wrap with kerlix and then ace wraps from foot to knee once a day with a start date of [DATE] and an end date of [DATE] and change dressing to bilateral lower extremities daily and prn, cover with Dakin's solution soaked gauze wet to dry dressing, cover with abdominal pads, wrap with kerlix then ace wraps from foot to knee with a start date of [DATE] and an end date of [DATE]. R1's Medication Administration Record (MAR) dated [DATE]-[DATE] documents the following treatment orders to R1's bilateral lower extremities:A treatment order of cleanse bilateral lower legs with Vashe. Pat dry. Apply exufiber to the affected areas with wounds. Cover with ABD (abdominal pads, thick absorbent pad) pads and secure with roll gauze daily and as needed until wounds are healed with a start date of [DATE] and an end date of [DATE]. This treatment was documented as not administered with a corresponding note of Not Administered: other comment: cleaned with wound cleanser, wrapped w (with) abds (abdominal pads) and kerlix and not administered on [DATE] with a note of Not administered: drug/item unavailable comment: cleaned legs with wound cleanser, wrapped with abs (abdominal pads) and kerlix. Dakins, Vashe, and exufiber unavailab [sic]. An order of Change drsgs (dressings) to BLE (bilateral lower extremities) daily & prn (as needed). BLE cover with Dakins-solution soaked gauze W/D (wet to dry) drsg (dressing). Cover with ABD's. Wrap with kerlix & then ACE wraps from foot to knee with a start date of [DATE] and an end date of [DATE]. This treatment is documented as not being administered on [DATE] with a note of Not Administered: Drug/Item Unavailable Comment: DAKINS and KERLIX unavailable. removed old dressing, cleaned with wound cleanser and rewrapped w/ace, not administered on [DATE] and [DATE] with a note of Not Administered: Drug/Item Unavailable, not administered on [DATE] with a note of Not Administered: Other Comment: cleaned with wound cleanser, wrapped w (with) ABD's and kerlix, and not administered on [DATE] with a note of Not Administered: Drug/Item Unavailable Comment: cleaned legs with wound cleanser, wrapped with ABD and kerlix. Dakins, Vashe, and exufiber unavailab [sic]. An order for Dakin's solution 0.25%, once a day, apply to wet-to-dry dressings to bilateral lower extremities daily with a start date of [DATE] and an end date of [DATE]. This treatment is documented as not administered on [DATE] with a note of Not Administered: Drug/Item unavailable and not administered on [DATE] with a note of Not Administered: Drug/Item Unavailable Comment: cleaned legs with wound cleanser, wrapped with abs [sic] and kerlix. Dakin's, Vashe, and (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	exufiber unavailab [sic]. R1's MAR dated [DATE]-[DATE] documents the following treatment orders to R1's bilateral lower extremities:A treatment order of Change drsgs to BLE daily & prn. BLE cover with Dakins-solution soaked gauze W/D drsg Cover with ABD's. Wrap with kerlix & then ACE wraps from foot to knee with a start date of [DATE] and an end date of [DATE]. This treatment is documented as not administered on [DATE] with a corresponding note of Not Administered: Other Comment: placed gauze soaked in Vershe [sic] on right leg and half of left leg, wrapped w (with) ABD's, kerlix, ace wraps. An order for Dakin's solution 0.25%, once a day, apply to wet-to-dry dressings to bilateral lower extremities daily with a start date of [DATE] and an end date of [DATE]. This treatment is documented as not administered on [DATE] with a corresponding note of Not Administered: Other Comment: placed gauze soaked in Vershe [sic] on right leg and half of left leg, wrapped w (with) ABD's, kerlix, ace wraps. A treatment order of Cleanse bilateral lower legs with Vashe. Pat dry. Apply exufiber to the affected areas with wounds. Cover with ABD pads and secure with roll gauze daily and as needed until wounds are healed with a start date of [DATE] and an end date of [DATE]. This treatment was documented as not administered on [DATE] with a corresponding note of Not Administered: Other Comment: placed gauze soaked in Vershe [sic] on right leg and half of left leg, wrapped w abds, kerlix, ace wraps. R1's Progress Note dated [DATE] at 5:05 PM by V12 (LPN) documents Res returned to facility at this time from app (appointment) @ (Consulting wound clinic) via facility transport. Facility transport driver, (Name) stating that res (R1) c/o (complained of) dizziness when first transporting to app & again when arriving to app. W/C (wheelchair) had to be used to transfer res (R1) into facility, BP (blood pressure) checked & (name) stated that it was extremely low, approx. (approximately) 70s/40s & that staff gave her juice & she felt better. Paperwork from app received w (with) N.Os. (new orders) Ertapenem (Invanz) 1G (gram) IM (intramuscular) once daily x14 days & Dakins Solution 0.25% wet to dry drsgs to BLE once daily. Awaiting delivery of meds from pharm. R1's Progress Note dated [DATE] at 5:50 PM by V12 documents When attempting to insert (consulting wound clinic name) N.O (new order) for Invanz solution, alerted of potential allergic rx (prescription) due to hx (history) of allergy to several similar abx (antibiotics) in past. Notifying oncoming shift of issue & to contact (consulting wound clinic name) to clarify if still wanting to be admin (administered) & just monitor res (R1) closely or change to diff (different) abx (antibiotic). R1's Progress Note dated [DATE] at 9:59 AM by V17 (RN) documents Saw NP (nurse practitioner) today. BLE weeping new dressing change today. Need clarification on ATB, rather or not one ordered or how long the FC (urinary catheter) is to be out. Resident (R1) sitting up in chair C/O great deal of pain. Pain meds (medication) given. Continue to monitor. R1's Progress Note dated [DATE] at 2:11 AM by V12 documents 0200 (2:00 AM) CNA notified signee at this time of res (R1) being in floor. CNA explaining that had just spoken to res (R1) @ 0130 (1:30 AM) about going to bed due to sleeping in recliner, res (R1) agreed & CNA assisted res (R1) up from recliner to ambulate to bed w wheeled walker & res (R1) stated she did not need anymore assistance. CNA then walking back up hall doing bed check when noticed res sitting in floor in front of recliner. Res (R1) A&O (alert and orientated) according to CNA, no visible injuries, res (R1) denied pain. Upon observation, res (R1) sitting in floor directly in front of recliner, feet out in front w (with) legs extended. Res (R1) A&O, verbal w SOB (shortness of breath), difficult to understand at times due to mumbling. Res (R1) denied pain & denied hitting head when asked. Res (R1) explained that fall occurred while attempting to transfer to bed after CNA had assisted res (R1) up to wheeled walker. Res (R1) denying slipping/tripping on anything, agreed that BLE had just given out. BLE wrapped w TXs (treatments) per norm, not suspected to cause fall due to being intact. Glasses on. Wheeled walker in front of res (R1), room free of clutter, well-lit. VS (vital signs): T (temperature) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	firm and intact. R1's Progress Note dated [DATE] at 1:31 PM by V2 documents Patient up per w/c (wheelchair) in room, short of breath, complaining of increased pain to BLE & generalized pitting edema to BIL (bilateral) Hands & BLE. V/S (vital signs) stable. Patient stated ‘just don't feel right.' 1pm (Doctor) notified of patient condition with new orders may send to ER (emergency room) to eval (evaluate) & treat. 1:05 pm POA (Power of Attorney) notified of patient condition & new orders received. 1:15 pm (local ambulance company) notified for transport. 1:28 pm (local ambulance company) here, patient assisted to stretcher & bed hold sent with patient with paperwork. 1:33 pm resident (R1) out of facility to (local hospital) ER via stretcher with (local ambulance company). R1's Progress Note dated [DATE] at 6:23 PM by V10 (RN) documents Signee called (local hospital) ER for update regarding res (R1) transfer. Nurse stated they transferred her to (different local hospital name) r/t (related to) septic shock. R1's Progress Note dated [DATE] at 3:51 PM by V20 (RN) documents (local hospital name) Nurse calls this facility to inform resident expired. R1's Hospitalist Discharge Summary from the local hospital documents that R1 was admitted to the hospital on [DATE] and discharged on [DATE] with final diagnoses including Septic shock secondary to skin and soft tissue infection (cellulitis) of bilateral lower extremities including infected venous ulcers, AKI (Acute Kidney Injury)/ATN (Acute Tubular Necrosis) with metabolic acidosis, Acute toxic metabolic encephalopathy, and Acute on chronic hypercapnic respiratory failure. This Discharge Summary documents a discharge destination of deceased in the hospital. The Hospital Course documents that R1 had VRE (Vancomycin-Resistant Enterococci) and MRSA (Methicillin-resistant Staphylococcus aureus) and bilateral lower extremity venous insufficiency/lymphedema and admitted overnight from an outside hospital with bilateral lower extremity wounds. R1 was admitted to ICU (Intensive Care Unit), started full aggressive medical care but with no improvement and continued clinical deterioration. R1's current clinical condition, risks, benefits and alternatives were discussed with R1's mother and daughter, and both understand R1 's continued suffering, repeated admissions, nonhealing extensive venous ulcers, poor baseline, functional status bed-bound at a nursing home and wanted to transition her to comfort measures. R1 passed away shortly after. R1's State of Illinois Certificate of Death Worksheet documents R1's date of death as [DATE], and cause of death documented as 1. Septic shock, 2. Skin and soft tissue infections, and 3. Methicillin-resistant staphylococcus aureus. R1's hospital records from the local hospital document under Microbiology-Lab Results dated [DATE] at 2:12 PM, under culture wound and gram stain, heavy pseudomonas aeruginosa with the source being ankle wound. On [DATE] at 11:46 AM, V10 (RN) stated she works night shift, so she never communicated with the consulting wound clinic directly regarding R1, so anytime she needed an order clarified with them she passed it along to the day shift nurse. On [DATE] at 1:45PM, V5 (CNA) stated she noticed R1's dressing was not getting changed often because the date on them would be old and the dressing would be unraveled and look very gross with drainage seeping through it, so she would tell the nurse working and they would tell her they would get to it as soon as they could. V5 stated it would eventually get changed because she would see it the next time she worked. On [DATE] at 1:13 PM, V6 (RN) stated there were several times she was unable to complete dressing changes on R1 per the order due to not having the correct supplies. V6 stated she would always do something if she didn't have the correct supplies, but it just might not be what the order says. V6 stated R1 was going to (outside wound clinic provider) to get dressing changes and when she came back with new a new order for Dakin's solution they tried to order it from the pharmacy, but they were supposed to order it through where they order other supplies not the pharmacy, so it took a while for them to get it. V6 stated they were out of Dakin's solution a lot of the time. V6 stated R1 came back from the hospital with orders for Vashe and exufiber at one point and the facility (continued on next page)

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 02/10/2026
NAME OF PROVIDER OR SUPPLIER Doctors Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Hawthorn Road Salem, IL 62881	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	didn't have either one. V6 stated she told V7 (Former DON), and she never saw the supplies show up. V6 stated they would also not have kerlix gauze wrap at times. V6 stated she never saw that the facility had exufiber for R1's wounds and maybe just one small bottle of Vashe that only did maybe two treatments but the rest of the times she did not use it for her treatments because she couldn't find any. On [DATE] at 3:04 PM, V12 (LPN) stated she took care of R1 and there were times they did not have the Dakin's solution or other supplies like they wouldn't have kerlix to wrap her legs with. V12 stated she always did something with her dressing but didn't always do what is ordered because of not having the correct supplies. V12 stated even when she didn't have the supplies, she still checked off she did the dressing per order in the MAR. V12 stated she works night shift, so she couldn't communicate with the office where R1 went for wound care. V12 stated when R1 was ordered Levaquin she never got it, but they started the Medrol dose pack because the day shift nurses told her they couldn't get clarification on the Levaquin.V12 stated it was difficult for her and she feels like she was constantly [NAME] her wheels since she worked nights and the office was closed when she was working so she couldn't communicate with them herself. V12 stated she doesn't remember R1 ever getting Invanz. V12 stated there was several times that R1 did not get her dressings changed when they were supposed to be and she would do it when she found it wasn't completed, V12 stated this happened at least twice a week. V12 stated R1's dressing change took a while to do because they were so extensive, and the day shift nurses would always say they didn't have time to do it. On [DATE] at 5:14 PM, V17 (RN) stated she did dressing changes on R1 and sometimes they wouldn't have Dakins solution so she would use normal saline wound cleanser and sometimes they wouldn't have other supplies either. V17 stated she would still change R1's dressing but she would just use what they had. V17 stated since she works night shift she never dealt with any orders from the wound clinic. On [DATE] at 11:29 AM, V20 (RN) stated he did dressing changes on R1 and he can for sure say they didn't have Dakin's solution most of the time and when they were out of Dakin's solution he doesn't remember what he would use but he did the best he could with what supplies they had on hand. On [DATE] at 2:03 PM, V21 (Family Member) stated she felt like the communicati[TRUNCATED]

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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 adhere to infection control protocols and failed to follow physician orders for wound care for 1 of 1 resident (R4) reviewed for pressure ulcers in a sample of 9. Findings include:R4's Face Sheet documents an admission date of 12/8/25 with diagnoses including in part muscular dystrophy, muscle wasting and atrophy, muscle weakness, osteomyelitis of vertebra sacral and sacrococcygeal region, paresthesia of skin, underweight, and multiple sclerosis. R4's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 15, indicating R4's cognition is intact. In Section M it documents under Determination of Pressure Ulcer/Injury Risk; A. R4 has a pressure ulcer/injury, a scar over boney prominence, or a non-removeable dressing/device. Under Unhealed Pressure ulcer/Injuries it documents R4 has a one or more unhealed pressure ulcers/injuries, and under Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage it documents R4 has 2 stage 4 pressure ulcers. R4's Care Plan documents R4 currently requires contact isolation for MRSA (Methicillin-Resistant Staphylococcus Aureus), ESBL (Extended-Spectrum Beta-Lactamase), and CRE (Carbapenem-Resistant Enterobacterales) of the nares, sacrum, and vagina with approach including contact isolation per policy and keep area covered/contained as indicated dated 12/9/25. The same Care Plan also documents R4 is at risk for skin breakdown or pressure ulcers related to decreased mobility, history or right wrist cockup splint, history of ulcer left heel and buttocks, current ulcer sacrum, vagina, history left thigh, contracture bilateral lower extremities, history of diarrhea, paresthesia skin, chronic osteomyelitis of the sacrum/coccyx, underweight, area of the vulva and right buttocks skin tear. R4's Physician Order Report dated 12/8/25-2/9/26 documents orders for isolation precautions related to MRSA, ESBL, and CRE with a start date of 12/8/25 and end date open ended and cleanse open area to sacrum, vulva and right buttock apply calcium alginate and Silvadene cream mixed with collagen powder and cover with silicone border dressing daily and as needed with a start date of 1/15/26 and a discontinue date of 1/23/26. R4's Wound Evaluation and Management Summary dated 1/16/26 documents R4's stage 4 pressure wound on the sacrum measures 5.6 x 7.9 x 0.5 cm (centimeter) and the wound progress is documented as improved, evidenced by decreased surface area. In the same document it documents R4's stage 4 pressure wound to the vulva is 3.5 x 4.6 x 0.5 cm and wound progress is improved, evidenced by decreased necrotic tissue, and R4's skin tear wound of the right lower buttock is 3.6 x 1.3 x 0.4 cm, and the wound progress is at goal. On 1/15/26 at 2:39 PM, V6 (Registered Nurse/RN) performed wound dressing changes to R4's wounds. V9 (Certified Nursing Assistant) and V10 (RN) assisted in positioning R4. At that time there was an enhanced barrier precaution sign on R4's door. V6, V9, and V10 were observed applying gloves, none were noted donning on any gowns during the observation. V6 removed the dressing on R4's sacrum and stated the dressing was dated 1/13/26, the dressing appeared to be dirty and soiled through the bandage with blood and green drainage. V6 removed the dressing on the right buttock and there was not a date on that dressing, the dressing was soiled with blood and green drainage. There was no dressing on the vulva wound. V6 cleansed each wound with normal saline wound cleanser then applied calcium alginate and Silvadene cream mixed with collagen powder. On 1/15/26 at 2:50 PM, V9 stated there is an enhanced barrier sign on R4's door but she forgot to wear a gown. V9 stated she is supposed to wear a gown during care for residents on enhanced barrier precautions and she should have worn one with R4. On 1/15/26 at 2:55 PM, V6 stated she worked on 1/14/26 and R6's wound dressings were not changed yesterday because she didn't have time to change them. V6 stated R4 did not refuse the dressing change she just didn't have time to do them. V6 stated R4's dressings are ordered to be changed daily and as needed. V6 stated there is a sign on (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's door for enhanced barrier precautions but she did not put on a gown because she didn't know she was on enhanced barrier precautions. V6 stated she should have worn a gown during care. V6 stated she could not find Silvadene cream that belonged to R4 so she just used another residents cream, but she can't remember which resident the cream belonged to. V6 opened the treatment cart drawers and looked for R4's Silvadene cream and was unable to find it. V6 stated she should not have used another residents prescribed wound medication. On 1/27/25 at 11:46 AM, V10 stated she forgot to wear a gown for wound care on R4 and she should have. V10 stated R4 is on contact isolation for infected wounds. On 1/15/26 at 10:19 AM, R4 stated she has several wounds, one on her tailbone, one close to her vagina, and one on her hip. R4 stated they usually change her dressings once a day, but they might miss one every so often. R4 stated when they change her wound dressings, they do it during the day, she doesn't want it done at night and if they try to do it during the night she won't let them because she wants to sleep. On 2/9/25 at 1:39 PM, V1 (Administrator) stated prescription wound creams are resident specific and a residents cream should not be used on a different resident. V1 stated she expects staff to wear the required personal protective equipment (PPE) when entering residents room that require contact isolation or enhanced barrier isolation. V1 stated when doing a wound dressing change the staff should wear a gown and gloves. V1 stated she expects nurses to follow physician's orders for wound care. A facility policy titled Isolation Precautions/Enhanced Barrier Precautions (EBP) dated April 1, 2024, documents enhanced barrier precautions are used in combination with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities. An undated facility policy titled Medication Administration documents under B. Administration, 15) Medications supplied for one resident are never administered to another resident. A facility policy titled Obtaining and Following Physician Orders dated July 2017 documents under Policy: it is the policy of the facility that physician orders will be obtained by licensed personnel and followed.