STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145247	A. Building B. Wing	04/15/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure call lights were answered timely for 2 of 4 (R1 and R2) residents reviewed for call lights in the sample of 14.Findings Include:1.R1's Resident Face Sheet with a print date of 4/11/26 documents R1 was admitted to the facility on [DATE] and discharged from the facility on 4/8/26, with diagnoses that include heart failure, age related physical disability, and diabetes.R1's MDS (Minimum Data Set) dated 2/27/26 documents a Brief Interview for Mental Status) score of 11, indicating R1 has a moderate cognitive deficit. This same MDS documents R1 was dependent on staff for toilet hygiene.R1's current Care Plan documents a Problem area with a start date of 2/24/26 of, Resident: admitted for skilled care. I require a Baseline Care Plan identifying care needs, risks, strengths, and goals within the first 48 hours. This Problem area includes the intervention with a start date of 2/24/26 of, Bowel and Bladder: I am incontinent for urine and toileting. I am incontinent of bowel and toileting. I require assistance to remain dry and clean. I use briefs, pads and I require assistance to maintain application and incontinent supplies as required.On 4/9/26 at 11:17 AM, V19 (Family Member) stated it takes longer for facility staff to respond to call lights in the evening and R1 had to sit in feces/urine for up to two hours.On 4/15/26 at 10:55 AM, V21 (Family Member) stated she arrived to the facility on an unknown date and R1's call light was on. V21 stated R1 had a bowel movement and had feces on him. V21 stated she waited 45 minutes after arriving at R1's room and then went and found staff to clean R1 up. V21 stated on another unknown date R1 had a bowel movement and they waited an hour for assistance before she left the room to locate a staff member to clean R1 up.2. R2's Resident Face Sheet with a print date of 4/11/26 documents R2 was admitted to the facility on [DATE] with diagnoses that include heart failure, anemia, chronic kidney disease, and overactive bladder.R2's MDS dated [DATE] documents a BIMS score of 15, indicating R2 is cognitively intact. This same MDS documents R2 is dependent on staff for toilet hygiene.R2's current Care Plan documents a Problem area with a start date of 3/11/26 of, Resident admitted to (name of facility) for skilled LTC (long term care) care. I require a Baseline Care Plan identifying care needs, risks, strengths and goals within the first 48 hours. This Problem area includes the intervention with a start date of 3/11/26 of, Bowel and Bladder: I am occasionally incontinent for urine and toileting. I am continent for bowel and toileting. I am at risk for bladder and bowel incontinence and require assistance to remain dry and clean. I use briefs and require assistance to maintain application and incontinent supplies required.On 4/9/26 at 10:25 AM, R2 stated it takes an hour or more for facility staff to answer call lights at times. R2 stated she is incontinent and had to sit in urine when it takes them longer.On 4/11/26 at 8:31 PM, when asked if they answer call lights timely, V12 (Certified Nursing Assistant/CNA) stated they do the best they can. V12 stated there are about 50 residents in the facility and at least 12 of them require assistance of two staff for incontinence care.On 4/11/26 at 8:37 PM, V13 (CNA) stated it usually takes 15-20 minutes to answer the call lights.On 4/11/26 at 8:45 PM, V14 (CNA) stated it takes 15-30 minutes to answer call lights at times. V14 stated three CNA's are not enough to meet the needs of the residents timely. V14 stated they have three CNA's and two nurses on the 12-hour night shift and one of the nurses leaves at 3 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM. When asked if residents get checked and changed timely. V14 stated they usually do but if they have call lights going off during bed checks then the call lights have to wait.On 4/12/26 at 2:36 PM, V15 (Licensed Practical Nurse/LPN) stated they have three CNA's and two nurses on the 12-hour night shift. V15 stated she is the only nurse from 3 am to 5 am. V15 stated, V2 (Director of Nurses/DON) comes in at 5 AM since there is only one nurse working. V15 stated during that time frame she is passing medications and doing treatments and answers call lights when she can. V15 stated the CNA's are doing bed checks during that time frame and they have to prioritize which call lights to answer. V15 stated some people may have to wait longer, especially if they have been on their light a lot and the staff know they have been cared for. V15 stated she wasn't aware of a negative impact that had occurred yet, but if something happened during that time frame, things that should get done wouldn't. V15 stated the staff provide good care, they are just burnt out from taking care of too many residents.On 4/12/26 at 7:03 PM, when asked if she had any concerns/complaints related to call lights being answered timely and/or incontinence care being provided timely, V6 (RN/Registered Nurse) stated, At night, yes, because I don't feel like we are adequately staffed. V6 stated all the night shift CNA's are good and work timely but they can only do so much when there is only three of them.On 4/12/26 at 8:27 PM, V2 (Director of Nurses) stated they have enough staff for the census but not for the acuity of the residents. V2 stated there are residents who require assist of two staff and if someone needs help while they are assisting those residents then they have to wait. When asked if answering call lights timely is an issue, V2 stated, I think they answer them as soon as they can. But when you are busy and doing something else it won't be soon. V2 stated if they are doing bed checks they can't answer call lights.On 4/11/26 at 9:11 PM, V1 (Administrator) stated they follow the state agency guidelines related to staffing. V1 stated they have three CNA's and one nurse from 3 AM to 6 AM.The facility policy titled Answering the Call Light dated July 2014 documents, Purpose: The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines.8. Answer the resident's call as soon as possible.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interview, and record review the facility failed to ensure comfortable water temperatures for 3 of 4 residents (R1, R2, and R14) residents reviewed for environment in the sample of 14.Findings Include: 1.R1's Resident Face Sheet with a print date of 4/11/26 documents R1 was admitted to the facility on [DATE] and discharged from the facility on 4/8/26, with diagnoses that include heart failure, age related physical disability, and diabetes.R1's MDS (Minimum Data Set) dated 2/27/26 documents a Brief Interview for Mental Status) score of 11, indicating R1 has a moderate cognitive deficit. This same MDS documents R1 is dependent on staff for bathing.R1's current Care Plan documents a Problem area with a start date of 2/24/26 of, Resident: admitted for skilled care. I require a Baseline Care Plan identifying care needs, risks, strengths, and goals within the first 48 hours. This Problem area includes the intervention with a start date of 2/24/26 of, Activities of Daily Living: Overall I require.extensive assistance with bathing.On 4/9/26 at 11:17 AM, V19 (Family Member) stated R1 no longer resided at the facility and would not be interviewable. V19 stated R1 took showers on Monday's and Thursdays and during his stay at the facility the water in the shower on R1's hall was cold.2.R2's Resident Face Sheet with a print date of 4/11/26 documents R2 was admitted to the facility on [DATE] with diagnoses that include heart failure, anemia, chronic kidney disease, and overactive bladder.R2's MDS dated [DATE] documents a BIMS score of 15, indicating R2 is cognitively intact. This same MDS documents R2 is dependent on staff for bathing.R2's current Care Plan documents a Problem area with a start date of 3/11/26 of, Resident admitted to (name of facility) for (skilled LTC (long term care) care (sic). I require a Baseline Care Plan identifying care needs, risks, strengths and goals within the first 48 hours. This Problem area includes the intervention with a start date of 3/11/26 of, Activities of Daily Living: Overall I require.extensive assistance with bathing.On 4/9/26 at 10:25 AM, R2 stated she showers twice weekly and hasn't had an issue with the water temperature. R2 stated she uses the shower on her hall to bathe in most of the time but has been taken to other halls to shower.3. R14's Resident Face Sheet with a print date of 4/11/26 documents R14 was admitted to the facility on [DATE] with diagnoses that include aphasia, hemiplegia, hemiparesis, history of falling, blindness, and anorexia.R14's MDS dated [DATE] documents R14 has a severe cognitive impairment and requires substantial/maximal assistance with bathing.R14's current Care Plan documents a Problem area with a start date of 6/26/25 of, Category: ADL's (Activities of Daily Living) Functional Status/Rehabilitation Potential: Resident needs lim/ext (limited/extensive) assist for activities of daily living r/t (related to): REQUIRES ASSIST, rt (right) hemiplegia. This Problem area includes the intervention with a start date of 6/26/25 of, Shower per shower day.The facility (name R1, R2, and R14's hall) Shower Schedule documents R1's shower days on Tuesday's and Friday's, R2's shower days on Wednesday's and Saturday's, and R14's shower days on Tuesday's and Friday's.On 4/9/26 at 9:29 AM, this surveyor with V2 (Director of Nurses) present verified the accuracy of the surveyor's thermometer by placing it in a cup of ice water. The thermometer read 33.6 degrees Fahrenheit. At 9:38 AM on this same day, this surveyor with V2 present entered the shower room on R1, R2, and R14's hall and checked the temperature of the water in the shower. The temperature reading was 98.4 degrees Fahrenheit. The water was allowed to run for several more minutes (untimed) and was rechecked and was 96.8 degrees Fahrenheit. V2 stated they rarely use this shower room. V2 stated she wasn't sure if the staff ever used this shower room.On 4/9/26 at 9:56 AM, V3 (Certified Nursing Assistant/CNA) stated she was working on R1, R2, and R14's hall and had not given any showers yet. V3 stated there were no showers scheduled but she did give showers on Monday and Tuesday of this week including R1's shower. V3 stated she used the shower on their hall and they didn't complain about the water temperature but she had to let it run for about ten minutes before it heated up.On 4/9/26 at 12:14 PM, V4 (Maintenance Director) stated he (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had an unknown housekeeper check the water temperature in R1, R2, and R14's shower room and the temperature was 98.6 degrees Fahrenheit. V4 stated he was taking residents on transports and when he returned he would adjust the temperature of the water. V4 stated today was the first time he was made aware the water temperature in that shower room was too low. V4 stated his goal temperature was 100-115 degrees Fahrenheit. V3 entered the room where this surveyor and V4 were talking and stated it takes 5-10 minutes to heat up. V4 left the room and returned sometime later and stated the water did not heat up to the correct temperature after running it for the suggested 5-10 minutes.On 4/9/26 at 2:03 PM, this surveyor and V4 entered R1, R2, and R14's shower room and checked the water temperature in the shower after V4 stated they had adjusted the temperature of the water. The water temperature was 104.2 degrees Fahrenheit on V4's thermometer and 105.6 degrees Fahrenheit on this surveyor's thermometer.The facilities untitled and undated policy documents, It is the policy of (name of facility) that the facility monitor and maintain a reasonable and comfortable temperatures and environment for the residents, employees, and guests. Procedure.3. A random sampling of water temperatures will be monitored routinely. 4. The hot water distribution systems shall be arranged to provide hot water of at least 100 degrees Fahrenheit at each hot water outlet at all times. 5. Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from misappropriation of medications for 3 of 3 (R3, R4, and R5) residents reviewed for abuse in the sample of 14.This past non-compliance occurred between 3/27/26 and 4/1/26.Findings Include:The Long Term Care Facility and IID (Individuals with Intellectual Disabilities) -Serious Injury Incident Report dated 3/28/26 documents under Detailed Incident Summary, Administration was notified of possible drug diversion at the facility regarding (R3's) oxycodone. It was discovered that (R3's) narcotic card had been tampered with and the medication in the card was metoprolol and not oxycodone. Investigation continued and MD (physician), POA (power of attorney) and local police were notified of the investigation. Nurses currently on shift were immediately drug tested and were negative. Call was made to (V7/Registered Nurse-RN) for interview and drug test. (V7) did not answer the call so the DON (Director of Nurses/V2) made arrangements to meet (V7) at the facility prior to her next shift for drug testing. Prior to her shift on 3/29/26, (V7) sent a text message to the DON and stated that she needed to take personal time due to mental health issues and would not be returning to the facility to participate in the investigation. The facility continued the investigation and found 2 additional cards of narcotics had been tampered with and the hydrocodone/acetaminophen had been replace [sic] with potassium 10 meq (milliequivalents). All nurses were then drug tested with the exception of (V7). The facility has not been able to make contact with her since the beginning of the investigation. All nurses' urine tests were negative. MD, POA's of affected residents, pharmacy, and police were notified of additional results of the investigation. Affected residents' medications has been replaced by the facility and no adverse drug reactions were observed on the residents. (V7) was terminated for suspicion of drug diversion, investigation is ongoing with (name of local police department).On 4/9/26 at 1:00 PM, V2 (Director of Nurses/DON) stated there were three residents whose medications had been tampered with, R3, R4, and R5. V2 stated she was notified on 3/27/26 by V15 (Licensed Practical Nurse/LPN) and V6 (RN/Registered Nurse) there was a card of narcotics missing. V2 stated she began an investigation, and they were able to locate the missing card of medications in the wrong section of the medication cart. V2 stated on 3/28/26 they discovered the labels had been switched on R3, R4, and R5's narcotics and the medications were replaced with Lopressor (metoprolol) and potassium. V2 stated they notified the local police department, the state police, the attorney general, and the Department of Professional Regulation. V2 stated they did drug screens on all licensed nurses except V7 (RN) who did not return to the facility and refused to participate in the investigation. V2 stated they drew potassium levels on the residents affected and they were within normal limits and monitored their blood pressures and remained within normal limits.1.R3's Resident Face Sheet with a print date of 4/9/26 documents R3 was admitted to the facility on [DATE] with diagnoses that include cerebral infarct, hemiplegia, and dependence on respirator.R3's Minimum Data Set (MDS) dated [DATE] documents R3 has a severe cognitive impairment.R3's current Care Plan documents a Problem area with a start date of 5/30/25 of, Resident has pain/risk for pain. Contractures, Hx (history) Pelvic Mass, nonverbal, chronic pain. Interventions for this problem area include, Meds (medications) per order report to MD (Physician) if ineffective/adverse effects.R3's Medication Administration Record (MAR) dated 3/1/26 to 3/31/26 documents a physician order for oxycodone 5/325 milligrams to be administered every 6 hours as needed. This same MAR documents the medications were administered as ordered and documented as effective at relieving the pain. This same MAR documents pain assessments were done each shift and pain scale ranges from 0-4.2.R4's Resident Face Sheet with a print date of 4/9/26 documents R4 was admitted to the facility on [DATE] with diagnoses that include pain in right ankle and joints.R4's MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 15, indicating R4 is cognitively intact.R4's current Care Plan documents a Problem area with a start date of 7/5/24 of, Resident has pain/risk for pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dx (diagnoses) rheumatoid arthritis, spinal stenosis, pain back and rt (right) shoulder, radiculopathy, arthropathic psoriasis, kyphosis, calciphylaxis, chronic pain. This Problem area includes the intervention of, Administer medication/patches per order report to md (physician) if ineffective/adverse effects.R4's MAR dated 3/1/26 to 3/31/26 documents a physician order for hydrocodone 10/325 milligrams administer four times a day as needed. This same MAR documents the hydrocodone was administered as ordered and the medication was effective in relieving the pain. This same MAR documents pain assessments were completed each shift, and the pain scale ranges from 0-8.On 4/11/26 at 6:48 PM, R4 denied concerns with medication administration. R4 stated her pain medication seems to run out faster than it should but denied concerns with it.3. R5's Resident Face Sheet with a print date of 4/9/26 documents R5 was admitted to the facility on [DATE] with diagnoses that include pain in right leg.R5's MDS dated [DATE] documents a BIMS score of 15, indicating R5 is cognitively intact.R5's current Care Plan documents a Problem area with a start date of 2/13/23 of, Resident has complaints of chronic pain R/T (related to) Dx (diagnoses), diabetic neuropathy, polyosteoarthritis, hx (history) Migraine, PVD (Peripheral Vascular Disease), pain legs/knees, OA (osteoarthritis) rt (right) knee. This Problem area includes the intervention of, meds (medications) per order and report to md if ineffective/adverse effects.R5's MAR dated 3/1/26 to 3/31/26 documents a physician order for hydrocodone 10/325 milligrams administer every four hours as needed. This same MAR documents the hydrocodone was administered as ordered and documents the medication was effective or somewhat effective. This same MAR documents pain assessments were completed each shift with the pain scale ranging from 0-8.On 4/11/26 at 7:04 PM, R5 denied concerns with her pain medication.On 4/11/26 at 10:16 AM, this surveyor attempted to contact V7 a voice mail was left requesting a return call. This surveyor was not able to make contact with V7.On 4/12/26 at 2:36 PM, V15 (Licensed Practical Nurse/LPN) stated she was working with V6 (Registered Nurse/RN) 3/27/26 and they did a pre-count before the next shift arrived. V15 stated she knew there had been 9 cards of narcotics delivered the night before and there were only 8 papers and cards. V15 stated they reported it to V2 (DON) and she began the investigation. V15 denied any concerns related to narcotics diversion prior to that.On 4/12/26 at 7:03 PM, V6 (RN) stated she was working with V15 on 3/27/26 and they started counting the narcotics cards and V15 stated she had received 9 cards of narcotics the previous shift, R3's oxycodone was one of them and was missing. V6 stated they called the pharmacy to verify one had been sent out and the pharmacy confirmed they had sent a new card out for R3 on 3/25/26. V6 stated she notified V2 (DON) it was missing. V6 stated V2 began an investigation and found narcotics had been replaced with other medications.On 4/11/26 at 9:47 PM, V8 (police officer) stated he was notified by V2 (DON) that narcotics were missing. V8 stated they noted the medication cards had been tampered with and believed V7 was the offender. V8 stated the facility started the investigation and V7 refused to give a drug test. V8 stated since V7 refused the drug screen the case was closed, as far as he was concerned.On 4/9/26 at 1:00 PM, V1 (Administrator) stated they did not have any other allegations of misappropriation of resident's medications. V1 stated an investigation was started immediately and all notifications were made. V1 stated they had been unable to obtain a written police report. In an email on 4/14/26 at 2:43 PM, V1 stated there were a total of 120 narcotics missing from R3, R4, and R5. The facility Abuse Prevention Program dated 11/26/25 documents Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.It includes verbal abuse, sexual abuse, physical abuse, and mental abuse.Misappropriation of resident property: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident consent.The facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management approach.Prior to the survey date, the facility took the following actions to correct the non-compliance:The facility QAPI (Quality Assurance and Performance Improvement) Ad Hoc Form dated 4/1/26 documents the following, 1. Immediate Corrective Action for those affected by the deficient practice: Suspected nurse suspended immediately pending investigation. Investigation initiated. (R3's) MD (Physician), POA (power of attorney), pharmacy, and local police notified. Nurses working during Drug test administered to nursed worked when the missing drug was noted. 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents have the potential to be affected. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur. Regional Clinical Director (V20) audited narcotics to ensure no other cards were tampered with on carts (North and Pheonix carts) and DON (V2) audited narcotics on [NAME] and Southwest halls. Licensed nurses educated on drug diversion policy, recognition of label/medication tampering, and reporting suspected diversion. DON (V2)/designee will visually audit narcotic supply to ensure there is no evidence of tampering 3 x (times)/week for 4 weeks. DON/designee will audit narcotic count sheets 2x/week for 4 weeks to ensure counts are correct. 4. Plan to monitor performance to ensure solutions are sustained. Administrator to monitor above and report findings/trends/issues to the QA (Quality Assurance) committee.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure incontinence care was provided timely for 2 of 4 (R1 and R2) residents reviewed for activities of daily living (ADL) in the sample of 14.Findings Include:1. R1's Resident Face Sheet with a print date of 4/11/26 documents R1 was admitted to the facility on [DATE] and discharged from the facility on 4/8/26, with diagnoses that include heart failure, age related physical disability, and diabetes.R1's MDS (Minimum Data Set) dated 2/27/26 documents a Brief Interview for Mental Status) score of 11, indicating R1 has a moderate cognitive deficit. This same MDS documents R1 is dependent on staff for toilet hygiene and has occasional urinary and bowel incontinence.R1's current Care Plan documents a Problem area with a start date of 2/24/26 of, Resident: admitted for skilled care. I require a Baseline Care Plan identifying care needs, risks, strengths, and goals within the first 48 hours. This Problem area includes the intervention with a start date of 2/24/26 of, Bowel and Bladder: I am incontinent for urine and toileting. I am incontinent of bowel and toileting. I require assistance to remain dry and clean. I use briefs, pads and I require assistance to maintain application and incontinent supplies as required.On 4/9/26 at 11:17 AM, V19 (Family Member) stated R1 had to wait for up to two hours for care to be provided after having a bowel movement. On 4/15/26 at 10:55 AM, V21 (Family Member) stated she arrived to the facility on an unknown date and R1's call light was on. V21 stated R1 had a bowel movement and had feces on him. V21 stated she waited 45 minutes after arriving at R1's room and then went and found staff to clean R1 up. V21 stated on another unknown date R1 had a bowel movement and they waited an hour for assistance before she left the room to locate a staff member to clean R1 up.2. R2's Resident Face Sheet with a print date of 4/11/26 documents R2 was admitted to the facility on [DATE] with diagnoses that include heart failure, anemia, chronic kidney disease, and overactive bladder.R2's MDS dated [DATE] documents a BIMS score of 15, indicating R2 is cognitively intact. This same MDS documents R2 is dependent on staff for toilet hygiene and has frequent urinary and bowel incontinence.R2's current Care Plan documents a Problem area with a start date of 3/11/26 of, Resident admitted to (name of facility) for (skilled LTC/long term care) care [sic]. I require a Baseline Care Plan identifying care needs, risks, strengths and goals within the first 48 hours. This Problem area includes the intervention with a start date of 3/11/26 of, Bowel and Bladder: I am occasionally incontinent for urine and toileting. I am continent for bowel and toileting. I am at risk for bladder and bowel incontinence and require assistance to remain dry and clean. I use briefs and require assistance to maintain application and incontinent supplies required.On 4/9/26 at 10:25 AM, R2 stated it takes an hour or more for facility staff to answer call lights at times. R2 stated she is incontinent and had to sit in urine when it took them longer.On 4/11/26 at 8:45 PM, V14 (CNA/Certified Nursing Assistant) stated it takes 15-30 minutes to answer call lights at times. V14 stated three CNA's are not enough to meet the needs of the residents timely. V14 stated they have three CNA's and two nurses on the 12-hour night shift and one of the nurses leaves at 3 AM. When asked if residents get checked and changed timely. V14 stated they usually do but if they have call lights going off during bed checks then the call lights have to wait.On 4/12/26 at 2:36 PM, V15 (Licensed Practical Nurse/LPN) stated they have three CNA's and two nurses on the 12-hour night shift. V15 stated she is the only nurse from 3 AM to 5 AM. V15 stated V2 (Director of Nurses/DON) comes in at 5 AM since there is only one nurse working. V15 stated during that time frame she is passing medications and doing treatments and answers call lights when she can. V15 stated the CNA's are doing bed checks during that time frame and they have to prioritize which call lights to answer. V15 stated some people may have to wait longer, especially if they have been on their light a lot and the staff know they have been cared for.On 4/12/26 at 7:03 PM, when asked if she had any concerns/complaints related to call lights being answered timely and/or incontinence care being provided timely, V6 (RN/Registered Nurse) stated, At night, yes, because I don't feel like we are (continued on next page)

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	145247	A. Building B. Wing	04/15/2026

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adequately staffed. V6 stated all the night shift CNA's are good and work timely but they can only do so much when there is only three of them.On 4/12/26 at 8:27 PM, V2 (Director of Nurses) stated they have enough staff for the census but not for the acuity of the residents. V2 stated there are residents who require assist of two staff and if someone needs help while they are assisting those residents then they have to wait.On 4/11/26 at 9:11 PM, V1 (Administrator) denied concerns and/or complaints related to timely incontinence care.The facility policy titled Toileting documents, Policy: It is the policy of (name of facility) to ensure all of our residents' toileting needs are met. Procedure.2. Check each resident every two hours and change if found incontinent.Ensure the call light is in within reach and answer ASAP (as soon as possible).

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a urinalysis was obtained timely for 1 of 3 (R1) residents reviewed for urinary tract infections in the sample of 14.Findings Include:1.R1's Resident Face Sheet with a print date of 4/11/26 documents R1 was admitted to the facility on [DATE] and discharged from the facility on 4/8/26, with diagnoses that include urinary tract infections.R1's MDS (Minimum Data Set) dated 2/27/26 documents a Brief Interview for Mental Status) score of 11, indicating R1 has a moderate cognitive deficit.R1's current Care Plan documents a Problem area with a start date of 2/24/26 of, Resident: admitted for skilled care. I require a Baseline Care Plan identifying care needs, risks, strengths, and goals within the first 48 hours. This Problem area includes the intervention with a start date of 2/24/26 of, Bowel and Bladder: I am incontinent for urine and toileting. I am incontinent of bowel and toileting. I require assistance to remain dry and clean. I use briefs, pads and I require assistance to maintain application and incontinent supplies as required.On 4/9/26 at 11:17 AM, V19 (Family Member) stated R1 received orders for a urinalysis and several days later the facility still wasn't able to obtain it. V19 stated he had R1 drink water, then helped him stand up and use the urinal and was able to obtain the urinalysis for the facility.R1's Physician Order Report dated 2/24/26 to 3/30/26 documents a physician's order with a start date of 3/27/26 of Culture, Urine; Urinalysis; Once- One Time; 05:30 AM.R1's Progress Notes document on 3/27/26 at 3:12 AM, Signee (V6 RN/Registered Nurse) attempted to obtain UA (urinalysis) via straight cath (catheter) x (times) 2 attempts and unsuccessful. Res (resident) stood up at bedside with assist from CNA's (Certified Nursing Assistants) and signee to see if he could urinate in urinal and unsuccessful. There is no further documentation related to the urinalysis until 4/1/26 at 5:57 AM when the progress note documented the urinalysis was obtained on the evening of 3/31/26 and sent to the laboratory on the morning of 4/1/26.R1's urinalysis report documents a collection date of 3/31/26 and reported on 4/2/26. The results included 2 plus blood, positive for nitrites, 2 plus leukocytes, greater than 50 white blood cells, and negative for bacteria. The culture and sensitivity report documents it was reported on 4/8/26 and documents greater than 100,000 colony forming units per milliliter of pseudomonas aeruginosa.On 4/12/26 at 7:03 PM, V6 (RN) stated she attempted to get a urinalysis on R1 on an unknown night and was unsuccessful. V6 stated she attempted to collect it via straight catheter and by having R1 urinate in a urinal with no success. V6 stated she reported it to the next shift, and she isn't sure what happened after that. V6 stated it shouldn't have taken four days to get the sample.On 4/12/26 at 8:27 PM, V2 (Director of Nurses) stated she was aware of an order for a urinalysis for R1 and that they had attempted to obtain via straight catheter with no result. V2 stated she knew the family had given them a urinal with urine in it and they educated them they couldn't use the urine since they didn't know how long it had been sitting. V2 stated they were finally able to get the sample. When asked if it was acceptable for it to take from 3/27/26 to 3/31/26 to obtain the sample, V2 stated, Really, probably not but if he is incontinent most times it is kind of hard to collect that.The facility Clinical Cultures policy dated 4/2015 documents, Policy: Cultures will be performed when necessary to determine the presence of absence of infection.Cultures are obtained as soon as practical when ordered.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure staffing is sufficient to meet the needs of the residents timely. This has the potential to affect all 50 residents currently residing at the facility. Findings Include:The facility Resident Roster dated 4/8/26 documents 50 residents currently reside at the facility.1.R1's Resident Face Sheet with a print date of 4/11/26 documents R1 was admitted to the facility on [DATE] and discharged from the facility on 4/8/26, with diagnoses that include heart failure, age related physical disability, and diabetes.R1's MDS (Minimum Data Set) dated 2/27/26 documents a Brief Interview for Mental Status) score of 11, indicating R1 has a moderate cognitive deficit. This same MDS documents R1 is dependent on staff for toilet hygiene.R1's current Care Plan documents a Problem area with a start date of 2/24/26 of, Resident: admitted for skilled care. I require a Baseline Care Plan identifying care needs, risks, strengths, and goals within the first 48 hours. This Problem area includes the intervention with a start date of 2/24/26 of, Bowel and Bladder: I am incontinent for urine and toileting. I am incontinent of bowel and toileting. I require assistance to remain dry and clean. I use briefs, pads and I require assistance to maintain application and incontinent supplies as required.On 4/9/26 at 11:17 AM, V19 (Family Member) stated it takes longer for facility staff to respond to call lights in the evening and R1 had to sit in feces/urine for up to two hours.2. R2's Resident Face Sheet with a print date of 4/11/26 documents R2 was admitted to the facility on [DATE] with diagnoses that include heart failure, anemia, chronic kidney disease, and overactive bladder.R2's MDS dated [DATE] documents a BIMS score of 15, indicating R2 is cognitively intact. This same MDS documents R2 is dependent on staff for toilet hygiene.R2's current Care Plan documents a Problem area with a start date of 3/11/26 of, Resident admitted to (name of facility) for (skilled LTC/long term care) care [sic]. I require a Baseline Care Plan identifying care needs, risks, strengths and goals within the first 48 hours. This Problem area includes the intervention with a start date of 3/11/26 of, Bowel and Bladder: I am occasionally incontinent for urine and toileting. I am continent for bowel and toileting. I am at risk for bladder and bowel incontinence and require assistance to remain dry and clean. I use briefs and require assistance to maintain application and incontinent supplies required.On 4/9/26 at 10:25 AM, R2 stated it takes an hour or more for facility staff to answer call lights at times. R2 stated she is incontinent and had to sit in urine when it takes them longer.On 4/11/26 at 8:31 PM, when asked if they answer call lights timely, V12 (Certified Nursing Assistant/CNA) stated they do the best they can. V12 stated there are about 50 residents in the facility at least 12 of them require assistance of two staff for incontinence care.On 4/11/26 at 8:37 PM, V13 (CNA) stated it usually takes 15-20 minutes to answer the call lights.On 4/11/26 at 8:45 PM, V14 (CNA) stated it takes 15-30 minutes to answer call lights at times. V14 stated three CNA's are not enough to meet the needs of the residents timely. V14 stated they have three CNA's and two nurses on the 12-hour night shift and one of the nurses leaves at 3 AM. When asked if residents get checked and changed timely. V14 stated they usually do but if they have call lights going off during bed checks then the call lights have to wait.On 4/12/26 at 2:36 PM, V15 (Licensed Practical Nurse/LPN) stated they have three CNA's and two nurses on the 12-hour night shift. V15 stated she is the only nurse from 3 AM to 5 AM. V15 stated V2 (Director of Nurses/DON) comes in at 5 AM since there is only one nurse working. V15 stated during that time frame she is passing medications and doing treatments and answers call lights when she can. V15 stated the CNA's are doing bed checks during that time frame and they have to prioritize which call lights to answer. V15 stated some people may have to wait longer, especially if they have been on their light a lot and the staff know they have been cared for. V15 stated she wasn't aware of a negative impact that had occurred yet, but if something happened during that time frame, things that should get done wouldn't. V15 stated the staff provide good care, they are just burnt out from taking care of too many (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents.On 4/12/26 at 7:03 PM, when asked if she had any concerns/complaints related to call lights being answered timely and/or incontinence care being provided timely, V6 (RN/Registered Nurse) stated, At night, yes because I don't feel like we are adequately staffed. V6 stated all the night shift CNA's are good and work timely but they can only do so much when there is only three of them.On 4/12/26 at 8:27 PM, V2 (Director of Nurses) stated they have enough staff for the census but not for the acuity of the residents. V2 stated there are residents who require assist of two staff and if someone needs help while they are assisting those residents then they have to wait. When asked if answering call lights timely is an issue, V2 stated, I think they answer them as soon as they can. But when you are busy and doing something else it won't be soon. V2 stated if they are doing bed checks they can't answer call lights.On 4/11/26 at 9:11 PM, V1 (Administrator) stated they follow the state agency guidelines related to staffing. V1 stated they have three CNA's and one nurse from 3 AM to 6 AM.The facility April 2026 Schedule Sheet for CNA's documents three CNA's work from 6 PM to 6 AM each night.The facility April 2026 Schedule Sheet documenting licensed nurse schedules document one licensed nurse working from 7 PM to 7 AM on 4/2, 4/3, 4/6, and 4/11 and on 4/1, 4/7, 4/8, and 4/9 there are two licensed nurses from 7 PM to 3 AM and one from 3 AM to 7 AM.The facility untitled and undated policy documents, The Facility provides adequate staff to meet needed care and services for our resident population and according to regulatory staffing requirements.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were crushed prior to administration for 1 of 3 (R1) residents reviewed for pharmacy services in the sample of 14.Findings Include:R1's Resident Face Sheet with a print date of 4/11/26 documents R1 was admitted to the facility on [DATE] and discharged from the facility on 4/8/26, with diagnoses that include dysphagia, oropharyngeal phase, heart failure, age related physical disability, and diabetes.R1's MDS (Minimum Data Set) dated 2/27/26 documents a Brief Interview for Mental Status) score of 11, indicating R1 has a moderate cognitive deficit. This same MDS documents R1 is dependent on staff for bathing.R1's current Care Plan does not document a Problem area related to medication administration.R1's Physician Order Report dated 2/24/26 through 3/30/26 documents an order dated 3/10/26 of Diet: Regular solids with Nectar liquids, add household shakes to all meals and an order dated 2/24/26 of May crush medications- do not crush enteric or time released medication.On 4/9/26 at 11:17 AM, V19 (Family Member) stated a nurse brought in R1's medications and attempted to give it to him whole with thin liquids when it was to be administered crushed and in applesauce and R1 was on thickened liquids.On 4/15/25 at 10:55 AM, V21 (Family Member) stated R1's medications were supposed to be crushed and administered in applesauce because he had swallowing issues. V21 stated she would tell them to crush them and put them in applesauce, so he didn't choke. V21 stated on unknown day V2 (Director of Nurses) entered R1's room with a smaller pill that was whole. V21 stated she reminded V2 that R1's medications were supposed to be crushed and V2 told her he could take the one smaller pill whole. V21 stated about an hour later R1 spit something out and he thought it was a tooth, but it was the pill he had kept in his mouth that whole time.The facility Grievance/Complaint Report dated 3/19/26 documents, (V19-family member) states DON (Director of Nurses/V2) was nurse on hall 3/16/26. Came to resident room (V21-family member and V19 was in room) gave resident a pill whole with regular water stating ?He does well with one pill.' (V19) stated he takes his medicine in applesauce and is on thick liquids. DON left room and medication was still in residents' mouth after she exited room. Under Documentation of Facility Follow -Up the report documents, Yes this did happen. I did crush med et (and) put in applesauce and give to resident.On 4/12/26 at 2:36 PM, V15 (Licensed Practical Nurse) stated R1 takes his medications crushed in applesauce.On 4/12/26 at 7:03 PM, V6 (Registered Nurse) stated R1 takes his medications crushed in applesauce.On 4/11/26 at 11:04 AM, V2 (DON) stated R1 can usually take one pill at a time with water. V2 stated it was a small pill, and she gave it to him whole with the water he had in his room that was thickened. V2 stated she left his room, and (V21) came out of the room with the pill that R1 had not swallowed. V2 stated she got R1 another pill, crushed it, and administered it.On 4/11/26 at 9:11 PM, V1 (Administrator) stated V2 went in to give R1 his medications and the (V19) reminded V2, R1 was on thickened liquids. V1 stated she got the thicken liquids and administered R1's medications with the correct consistency water.The facility was unable to provide a policy related to this specific deficient practice.