STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146046	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Rehab & Nursing	410 North Second Street Marshall, IL 62441

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 - Minimal harm or potential for actual harm 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 observation, interview and record review the facility failed to prevent cross contamination during wound care for one (R10) resident out of three residents reviewed for wounds in a sample list of 13 residents.Findings include:R10's Minimum Data Set (MDS) dated [DATE] documents R10 as moderately cognitively intact. This same MDS documents R10 requires assistance with toileting and personal hygiene.R10's Physician Order Sheet (POS) dated February 2025 documents a physician order starting 2/23/26 to apply a Hydrocolloid dressing to R10's Coccyx area every other day.R10's Wound Progress Note dated 2/23/26 documents R10's open area on R10's Coccyx as Moisture Associated Skin Dermatitis (MASD). On 2/25/26 from 9:00 AM-1:00 PM, R10 sat up in R10's wheelchair without being provided incontinence care. On 2/25/26 at 2:35 PM, V11 Licensed Practical Nurse (LPN) and V23 LPN completed wound care for R10. V11 LPN gathered the necessary supplies of gauze, dressing, scissors and wound cleanser by holding them against her jacket with her arms. V11 LPN was wearing a zip up hoodie style jacket. V11 LPN placed R10's wound supplies on her bedside table prior to ensuring R10's bedside table was disinfected. The previous dressing was a simple foam dated 2/23/26. R10's Coccyx showed an open, red wound approximately the size of a quarter size with a non-blanchable peri wound. R10 also had a separate open, red, line shaped open wound approximately an inch long. On 2/25/26 at 2:50 PM, V11 LPN stated she contaminated R10's supplies by holding them against her contaminated jacket. V11 LPN stated R10's open Coccyx wound was the size of a pencil eraser 'a few days ago'. V11 LPN stated R10 did not have any open areas on R10's Right Buttock. V11 LPN stated R10's Coccyx wound had worsened.On 2/25/26 at 3:15 PM, V16 LPN/Wound Nurse stated the staff do not lay R10 down after breakfast as they should and that is why R10 has open areas on R10's bottom. V16 stated she was not aware that R10's Coccyx wound had worsened nor that R10 had a new area on R10's Right Buttock.On 2/25/26 at 3:30 PM, V2 Director of Nurses (DON) stated staff should provide incontinence care for residents every two hours and as needed. V2 DON stated the expectation is for staff to provide preventative cares such as repositioning and toileting in order to prevent wounds from happening. V2 DON stated R10 is incontinent and requires assistance with incontinence care.

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 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 observation, interview and record review the facility failed to prevent cross contamination during incontinence care for one (R6) resident out of three residents reviewed for incontinence care in a sample list of 13 residents.Findings include:R6's Minimum Data Set (MDS) dated [DATE] documents R6 as cognitively intact. This same MDS documents R6 requires assistance with toileting and personal hygiene.On 2/24/26 at 1:50 PM V5 and V6 Certified Nurse Aides (CNA) completed incontinence care for R6. R6's bedside table was not disinfected prior to V5 placing clean dry washcloths on the bedside table. V5 CNA repeatedly used both gloved hands to provide front perineal care, then used both contaminated hands to obtain and wring out a washcloth that was sitting in a basin of warm water. After V5 CNA completed front incontinence care, R6 was assisted to R6's left side. R6 stated 'Oh! I am going again'. As R6 was urinating again, V5 CNA used the contaminated incontinence brief to 'catch' R6's urine. V5 CNA did not provide front perineal care after R6 urinated. V5 CNA used contaminated gloves to pull out the urine saturated incontinence brief and then placed a new brief without washing her hands, changing her gloves or using hand hygiene. V5 CNA did not apply barrier cream after completing incontinence care for R6. On 2/24/26 at 2:05 PM, V5 CNA stated V5 should have provided incontinence care after R6 urinated. V5 stated V5 should have changed V5's gloves after touching contaminated items and before placing the new incontinence brief. V5 stated V5 contaminated the clean wash water each time V5 used her contaminated gloved hands to dip into the water. On 2/24/26 at 2:15 PM, V2 Director of Nurses (DON) stated staff should remove their gloves, wash their hands and then reapply clean gloves when their gloves become contaminated. V2 DON stated staff are supposed to prevent cross contamination. V2 DON stated she will in-service staff on infection control/cross contamination.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure resident meals are palatable. This failure has the potential to affect all 58 residents residing in the facility.Finding include:The Facility Daily Midnight Census documents 58 residents reside in the facility.The Facility Grievance concern dated 12/1/25 documents the food was ‘cold'. On 2/24/26 at 1:00 PM, Resident meal trays were sitting in the main dining room with more than half of the food left on each of twelve trays.On 2/25/26 at 12:55 PM, Resident meal trays were sitting in the main dining room with more than half of the food left on each of fifteen trays.On 2/25/26 at 1:15 PM, the facility provided a test tray. V8 Certified Dietary Manager (CDM) obtained the temperature of the beef stew at 132 degrees Fahrenheit. The beef stew and mixed vegetables did not taste warm.On 2/24/26 at 1:00 PM, R11 stated his meal was cold. R11 stated his food looked like ‘slop' and would not serve it to anyone he cared about. R11 stated the food is always cold and does not taste good. R11 stated the food is frequently over cooked causing it to be burned or dried out. On 2/24/26 at 1:10 PM, R2 stated the facility food is usually served cold. R2 stated he was served cold pancakes and they were not edible. R2 stated he prefers to eat his meals in his room and states that may be part of the problem. R2 stated he has complained about this before, so the facility bought ‘pucks' to heat up and place under the plates. R2 stated sometimes the pucks are not even warm and sometimes the staff forget to use the pucks altogether. On 2/25/26 at 2:00 PM, V1 Administrator stated she is aware there have been multiple complaints about the food being served cold or not tasting good. V1 Administrator stated the facility is working on this problem and hopes to have it resolved soon.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to prevent cross contamination during meal service. This failure has the potential to affect all 58 residents residing in the facility.Findings include:The Facility Daily Midnight Census documents 58 residents reside in the facility.On 2/25/26 at 11:10 AM, the facility kitchen air conditioning unit hanging on the inside of the facility kitchen was dripping water onto the dishwashing area and onto the floor splashing over three to four feet to the food service area. On 2/25/26 at 11:40 AM, V8 Certified Dietary Manager (CDM) accidentally knocked the resident paper meal tickets off of the counter during meal service. V8 used gloved hands to pick up all the food service paper tickets that had spread over a three to four foot area on the kitchen floor. V8 CDM then placed the meal tickets back on the corner of the warmer counter. V22 [NAME] was also present when this occurred and assisted in picking up the meal tickets. V22 [NAME] then took the pile of contaminated meal tickets and placed them on resident meal trays to serve to the residents. On 2/25/26 at 1:20 PM, V8 Certified Dietary Manager (CDM) stated the facility air conditioner ‘broke' earlier this morning (2/25/26). V8 stated the air conditioner was dripping condensate ‘all over the kitchen' but the facility has called a service worker to get the problem fixed. V8 CDM stated This doesn't look good. What a day for this to happen! V8 CDM stated V8 should have re-printed the paper meal tickets due they became contaminated when they all touched the floor. V8 CDM stated V8 and V22 both picked up the tickets and put them on the meal trays. V8 stated the tickets stay with the meal trays so there is a good chance all of the trays would have been contaminated. V8 CDM stated the facility is going to start placing the meal tickets in a small metal pan to help prevent them from being knocked off again.