STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145247	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on record review, interviews, and observations, the facility failed to provide maintenance and/or sanitary conditions for resident bathrooms for 2 residents (R37, R72), resident communal bathrooms on all hallways and ceiling air conditioning units on all hallways. The findings include: These observations were made during the environmental tour on 9/28/2020: 1.) The 100, 200, 300 and 400 Hallway's main air conditioning units located on the ceiling in the middle of each hallway were unclean with large noticeable clumps of dirt/dust on the air return and visible mildew on all the surrounding ceiling tiles. On 10/01/2020 at 9:50 AM, V26, Director of Maintenance, stated the filters in the ceiling air conditioning units should be changed once a week, and the vents should be wiped off then also. 2.)The 300 Hall bathroom had dirt around the fixtures on the sink with unclean caulk. There were broken tiles in the bathroom and shower stall, and the shower stall was unclean. The area around the bottom of the toilet was unclean. The ceiling air conditioning unit vent was unclean. The hallway had an overall unpleasant odor. 3.)The 200 Hall bathroom had 8 broken tiles and the area around the bottom of the toilet was soiled with a yellow/brownish crusty substance. 4.) On 9/28/2020 at 9:40 AM, R72 said she has a problem with the floor in the bathroom attached to her room. R72 said that the vinyl floor is raised up and is a hazard. The bathroom floor covering was observed to be curled up from the floor at the door entrance to the toilet room, at more than half of the width of the door entry and raised up more than 1 inch from the floor. R72's sink was located inside of her room, and the faucet would not shut off completely and allowed water to flow out continuously. The entry from the hallway into R72's room was also noted to be missing a transition strip. In the 100 hall, the following rooms were missing the transition strips: 103, 105, 106, 108, 109, 111, 113, and 116. 5.) The 100 Hall shower room was noted to have crumbling plaster and displaced vinyl cove at the base of the door inside the shower room. An opposite inside shower door area was noted to have a 7 x 3 inch opening in the wall at the base of the door, due to missing plaster or tile. 6.) On 9-28-2020 at 10:30 AM, R37 said the bathroom attached to her room is unclean and the toilet leaks every time it is flushed. R37's bathroom was noted to have large amounts of dirt/mildew encrusted caulk around the toilet base, and when flushed, clear fluid seeped out from the base of the toilet and moistening the floor around the toilet base. 7.) On 9/29/2020 at 10:00 AM, the 300 Hall shower room was noted to have multiple unlabeled toiletry items that were left out of the storage cabinet in 3 basins which were resting on top of 2 plastic toilet seat risers. The larger toilet seat riser had a 3 inch length brown smear of feces on the outer rim. All of these items were being stored on the top of a shower cart. Other items on the shower cart included a scrub brush, a wheelchair foot pedal, a roll of plastic trash bags, and a bed pillow. The shower cart had a blue vinyl pad that was noted to have cracks in the vinyl. The shower cart was located against the wall of the shower room, beneath an unlocked toiletry cabinet. The toiletry cabinet contained 2 unlabeled stuffed animals and more unlabeled toiletry items. The wooden handrails in the shower/toilet room had worn off varnish on the surface. The floor heating vent was dirty, without a cover and had exposed sharp metal edges near the floor, for the length of approximately 4 feet. There was an exposed open drain hole, approximately 1 - 2 inches in diameter on the floor next to the shower cart from plumbing that had been removed. There were items such as a red metal piece of a wheelchair or walker, an unknown piece of equipment device, and an unlabeled roll-on deodorant left out on a shelf next to the unlocked toiletry cabinet. There were 2 soiled wheelchair foot pedals in the corner of the floor, resting on top of a soiled black computer laptop type bag. A water stained, undated sign was taped to the wall next to the soap dispenser on the shower stall that read: CNAs, (Certified Nurse Aides), the shower room is to be kept clean at all times. Clean up the BM, (Bowel Movement), left in the shower stall after your selfs, this is uncalled for. There was an unlabeled hand and body lotion container on top of the soap dispenser. There was a dried, soiled wash cloth hanging from the metal handrail in the shower stall. On 9/30/2020 at 4:00 PM, V1, Administrator, stated that the sign had been in the shower room for a very long time. The Residents Census and Condition report dated 9/28/2020 documented a census of 69.
F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** Based on observation, interview, and record review, the facility failed to assure safe and sanitary transport of food to residents by assuring all food items were covered during transport to their rooms. This has the potential to affect nine (R17, R23, R39, R43, R49, R51, R58, R66, R72) residents out of 61 residents that received food trays. Findings include: Starting at 11:45 AM on 9/28/2020 and continuing throughout the kitchen service, V20 (Culinary Assistant) and V21 (Culinary Assistant) prepared the trays for the residents lunches. While preparing the trays for transport to the resident's rooms, V20 and V21 failed to cover the deserts on nine trays (R17, R23, R39, R43, R49, R51, R58, R66, R72), leaving them exposed to the open air during transportation to the residents rooms. On 9/29/2020 starting at 12:00 PM and continuing throughout the dining service, all trays that were not enclosed in transport boxes did not have the dessert portion of their lunch covered for transport. This encompassed nine trays equaling nine desserts not covered. On 9/30/2020 at 1:50 PM, V18, Culinary Director, stated that all items on the trays should have been covered.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 assure residents received food at an appetizing temperature. This has the potential to affect four (R37, R63, R67 and R72) of 61 residents that received food trays. Findings include: On 9/28/2020, R37, R63, R67, and R72 all said their food is always unappetizingly cold when they receive their meal trays. All said they eat their meals in their rooms due to current Covid-19 restrictions. On 9/29/2020 starting at 12:08 PM throughout tray delivery service, trays were brought to the hallway for delivery with some trays waiting up to 43 minutes in the tray box. On 9/30/2020 at 11:40 AM, V18, Culinary Director, delivered the tray box to the 400 hall and notified staff lunch had arrived. At 11:56 AM, V18, Culinary Director, delivered the tray box to the 300 hall and notified the staff lunch had arrived. On 9/30/2020 starting at 11:40 AM throughout tray delivery service, trays were brought to the hallway for delivery with some trays waiting up to 42 minutes in the tray box. On 9/30/2020 at 12:33 PM, a test tray was ordered and exchanged for a tray being served on the 300 hall. The main dish, beef and broccoli had a temperature of 89.6 degrees Fahrenheit, and the rice had a temperature of 89.3 degrees Fahrenheit. Both items were cold and tasted unappetizing. On 10/01/2020 at 10:30 AM, V18, Culinary Director, said 61 of the 69 residents residing at this facility received food trays.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation , interview, and record review, the facility failed to wear gowns and gloves and wash their hands when entering and exiting resident rooms that were designated as isolation rooms for 5 of 5 residents on quarantine. Findings include: 1. On 9/28/2020 at 1:20 PM, V12, Licensed Practical Nurse (LPN) , said we have a hard time keeping track of which residents require isolation precautions. V12 said the following residents; R5, R8, R46, R67 and R71, are on quarantine status and staff should follow isolation practices when entering these rooms. V12 said gowns gloves and masks should be available outside of residents rooms, however, the storage containers get moved around. On 9/28/2020 at 11:30 AM, V10 (Licensed Practical Nurse/LPN) , entered R8 and R71's rooms to check their blood sugar levels and administer insulin. V10 did not put on a gown prior to entering R8's room. A sign on the door to R8's room read, Stop, Report to Nurse before you enter. V10 said it is difficult to keep track of who is on isolation precautions and who is not. V10 entered R71's room at approximately 11:40 AM. There was no sign on R71's door. However, there was a storage container in front of R71's room containing gowns, gloves, and masks. On 9/28/2020 at 1:20 PM, R5's call light was on. R5 had been to the [MEDICAL TREATMENT] Center earlier in the day. R5 was coughing and said she was cold. V11 (Certified Nurse Aide) entered R5's room. V11 did not put on a gown or gloves when she entered R5's room. V11 left R5's room, used hand sanitizer, and entered R71's room. V11 did not wear a gown or gloves when she entered R71's room. On 9/28/2020 at 1:08 PM, V11 delivered lunch trays to R8 and R71. V11 did not wear a gown before entering these rooms. V11 did not wash her hands after exiting these rooms. On 09/30/2020 at 8:22 AM, V16 (LPN/Treatment Nurse) , did not wear a gown in R67's room when she changed bandages and applied ointment to R67 's foot. On 9/30/2020 at 1:10 PM, V11 began picking up meal trays when residents were finished eating. V11 placed the trays in the food transportation cart. V11 did not wear a gown or gloves when she entered R8, R46 and R71's rooms. V11 did not wash her hands or use hand sanitizer before entering the rooms. During an interview with V1, Administrator, on 9/29/2020 at 11:24 AM, he stated staff should put gowns and gloves on before entering resident rooms who require isolation precautions. V1 said staff should wash their hands when they leave these rooms. The facility undated Covid -19 Preparedness Policy, under New Admissions, the fifth bullet point documents , Newly admitted or readmitted patients will be monitored for evidence of COVID-19 for 14 days after admission using Transmission -Based Precautions in a separate area or a single -person room. The section of the policy addressing outbreak management documents essential staff entering rooms/wings will utilize appropriate PPE and respiratory protection. PPE includes: Gloves, Gown, Medical face mask and Hand Hygiene before and after all patient contact, contact with infectious material and before and after removal of PPE including gloves. Electronic medical records document, R8 was readmitted to the facility 9/23/2020. R46 was readmitted on [DATE]. R71 was readmitted on [DATE]. R67 was admitted on [DATE] . R5 is transported to and from the [MEDICAL TREATMENT] Center every week on Mondays, Wednesdays and Fridays. The Residents Census and Condition report dated 9/28/2020 documented a census of 69.