Illinois D	epartment of Public	Health			FORM	APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
					с	
	IL6002539		B. WING			12/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
DOCTOR	S NURSING & REHA	B CENTER		AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IL 62881 ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga	ation 24510088/IL182309				
	Complaint Investiga	ation 2459972/IL182100				
S9999	Final Observations		S9999			
	Statement of Licensure Violations					
	300.3120h)1)A)					
	Section 300.3120 H Conditioning System	leating, Ventilating, and Air ms				
	Systems 1) Areas of a nu of the nursing home heated by means o heating equipment. air-conditioning and without limitation, b such as sitting room rooms, community (Section 3-202(8) o A) The mechan of maintaining a ter	nical system shall be capable nperature of at least 75 t, pursuant to the requirements				
	Based on observati review the facility fa temperatures of at	vas not met as evidenced by: ion, interview, and record ailed provide room least 75 degrees Fahrenheit (R1-R9) reviewed for				
	environment in a sa The findings include	ample of 9.				
BORATORY	tment of Public Health / DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIC	GNATURE	TITLE		(X6) DATE 12/23/24

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If continuation sheet 1 of 8

Illinois D	Department of Public	Health			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	IL6002539		B. WING		C 12/12/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ПОСТОВ	RS NURSING & REHA	B CENTER 1201 HAV	WTHORN ROA	\D		
DOCTOR		SALEM,	IL 62881			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	under 5 blankets wi his feet. R2 (R1's) r wheelchair in their r coat. R2 said it had and that was why R (Housekeeping Sup the heating unit in F pushed the red butt amount of cold air s heating unit. V7 sai R2's heating unit wa heating unit did not temperature, only th temperature adjusti R1 and R2's heating markings around th	:12 AM, R1 was lying in bed ith another blanket covering room dressed and wearing his been really cold in their room 22 was wearing his coat. V7 bervisor) was asked to turn on R1 and R2's room. When V7 ton on the heating unit a small started blowing out of the d she did not know if R1 and as working. R1 and R2's have a knob to adjust the he small metal piece the ment knob would connect to. g unit did not have any le temperature control knob at temperature the heating unit				
	his current room "a the heat and air uni since he had moved the summer the fac conditioning unit tha R1 pointed to the w still see the marks I R1's window had a slightly tacky to the his bed and said, "it night."	AM, R1 said he had been in couple of months." R1 said t in his room had not worked d to that room. R1 said during sility had provided an air at hooked up to his window. indow and said, "look you can eft by the tape they used." blackish residue that was touch. R1 had 5 blankets on t was terribly cold in here last				
	admission date of 5 documented R1 ha since 8/27/24. R1 M documented a Brief	e Sheet documented an 5/1/24. R1's Resident Census d resided in his current room Ainimum Data Set (MDS) f Interview for Mental Status ndicating R1 was moderately				

STATEMEN	Department of Public NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	COM	E SURVEY PLETED
	IL6002539		B. WING			C 12/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DOCTOF	RS NURSING & REHA	B CENTER	WTHORN ROA IL 62881	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	nge 2	S9999			
	cognitively impaired	d.				
	admission date of ' Census documente current room since documented a BIM was moderately co On 12/6/24 at 10:2 to the maintenance handheld thermom thermometer gun to room and said the degrees Fahrenhei thermometer gun to 2. On 12/6/24 at 10 his room was not w before this investig room his hands we his room was blow thermometer gun p	S score of 9, indicating R2 gnitively impaired. 1 AM, V4 (Housekeeper) went e shed and brought back a eter gun. V4 shot the owards the wall of R1 and R2's room temperature was 64.9 t (F). V4 gave the handheld	3			
		2 PM, R3 said he was freezing I dressed and covering himsel				
	admission date of Census documente current room since	e Sheet documented an 11/21/24. R3's Resident ed R3 had resided in his 11/21/24. R3 11/25/24 MDS S score of 14, indicating R3 act.				
nois Dena	always cold. R4 sa had not worked sin	2:35 PM, R4 said his room was id the heating unit in his room ce he had resided in his room. noved into his room V3				

		Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	IL6002539		B. WING		C 12/12/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
DOCTOR	S NURSING & REHA	B CENTER 1201 HAV SALEM, I	VTHORN ROA L 62881	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	unit in his room did summer months a v been put in his room V3 the facility was to cooling units in all ro expensive.	tor) had told R4 the heating not work. R4 said during the window unit air conditioner had n. R4 said he had been told by rying to get new heating/ esident rooms, but it was too				
	admission date of 7 documented R4 had since 7/12/24. R4's	e Sheet documented an 7/12/24. R4's Resident Census d resided in his current room 10/14/24 MDS documented a ndicating R4 was cognitively				
	thermometer gun pe of R5's room registe	:35 AM, using a handheld ointed at the floor in the center ered 67.1 degrees F. R5's ned on making a squealing out cold air.				
	3 blankets. R5 said had not worked sind	PM, R5 was lying in bed under the heating unit in her room ce she had moved into the leating unit just made a blew out cold air.				
	admission date of 7 documented R5 had since 2/7/23. R5's 1	e Sheet documented an /18/14. R5's Resident Census d resided in her current room 0/28/24 MDS documented a ndicating R5 was cognitively				
	wheelchair in her ro was always so cold around the heating	30 PM, R6 was sitting in a oom under a blanket. R6 said it in her room. The housing unit had a gap where the en from inside R6's room.				

Illinois D	epartment of Public	Health			FORM	APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	IL6002539		B. WING		C 12/12/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
DOCTOR	S NURSING & REHA	R CENTER 1201 HAV	VTHORN ROA	ND		
DOCTOR		SALEM, I	L 62881			-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	thermometer gun p	PM, using a handheld ointed at the floor in the center ered 68.4 degrees F.				
	admission date of 1 Census documente since 11/20/24. R6'	e Sheet documented an 1/20/24. R6's Resident ed R6 had resided in her room s 11/24/24 MDS documented , indicating R6 was cognitively				
	6. On 12/6/24 at 1:3 room was blowing o	30 PM, R7's heating unit in his out cold air.				
	always been very c	3 AM, R7 said his room had old. R7 said he did not think iis room had ever worked.				
	admission date of 1 Census documente current room since	e Sheet documented an 1/24/24. R7's Resident ed R7 had resided in his 11/24/24. R7's 11/26/24 MDS S score of 15, indicating R7 ct.				
	recliner in her room blanket. R8 said the in her room since s said she had told st	22 PM, R8 was sitting in her covered up with a thick e heating unit had not worked he had been admitted. R8 taff the heating unit was not , "they know it is cold in here."				
	thermometer gun p	PM, using a handheld ointed at the floor in the center ered 67.8 degrees F.				
	admission date of 1 Census documente	e Sheet documented an 1/21/24. R8's Resident ed R8 had resided in her 11/21/24. R8's 11/25/24 MDS				

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STATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	IL6002539		B. WING	B. WING		C 12/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
DOCTOR	S NURSING & REHA	B CENTER 1201 HAY SALEM,	NTHORN ROA IL 62881	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
	documented a BIM was cognitively inta	S score of 15, indicating R8 ct.				
	wheelchair in her ro blankets. R9's heat air. R9 said, "It was they covered me up the heat is working sure if the heat had handheld thermome	:00 AM, R9 was sitting in her oom covered with two ing unit was blowing out cold so cold in here last night but o real good. And I don't think in here." R9 said she was not ever worked in her room. A eter gun pointed at the floor in oom registered 68.0 degrees				
	admission date of 1 documented R9 ha since 11/8/24. R9 M	e Sheet documented an 1/8/24. R9's Resident Census d resided in her current room 1DS documented a BIMS ing R9 was cognitively intact.				
	Assistant/ CNA) sai she worked had no gotten cold outside.	PM, V5 (Certified Nursing id the heating units on the hall t been working since it had . V5 said she had reported all ot working to V3 previous to				
	DON) was asked if units in R1, R2, R5, attempted to turn of	1 AM, V2 (Director of Nursing/ she could turn on the heating , and R8's rooms. V2 n the heating units and said 8's heating units were not lowing out cold air.				
	could turn on the he V2 attempted to tur	AM, V2 was asked if she eat in R3, R4, and R9's rooms. n on the heating units and 9's heating units were not lowing out cold air.				

If continuation sheet 6 of 8

STATEMEN	epartment of Public	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BERTH IOATION NOMBER.	A. BUILDING:		
	IL6002539		B. WING		C 12/12/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
DOCTOF	RS NURSING & REHA		WTHORN ROA IL 62881	AD	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE DATE
S9999	Continued From pa	age 6	S9999		
	he was not aware o working in resident	9 AM, V1 (Administrator) said of any heating units not rooms. V1 said V3 was not in me but was hoping he would			
	the heating unit wa system. V3 said the heating units in all t R6's room with the could be seen throu previous Maintenar	PM, V3 said the rooms where sn't working used the boiler e facility was trying to get new the resident rooms. V3 said housing unit where the outside ugh was the work of the nce Director and V3 would he housing around the heating			
	2024 Daily Temper temperatures were facility with checkm temperatures were 2024 Quarter Air C	documented. The facility's onditioning/ Heat Maintenance units were operational and no			
	National Oceanic a Administration's (N Service (https://www.weath Climatological Data in) from 12/1/24 thr temperature was 1- highest temperatur and from 11/1/24 th temperature was 2	rical data provided from the and Atmospheric OAA) National Weather er.gov/wrh/climate?wfo=lsx) a for (the city the facility resides rough 12/11/24 the lowest 4 degrees Fahrenheit and the e was 57 degrees Fahrenheit, nrough 11/30/24 the lowest 1 degrees Fahrenheit and the e was 72 degrees Fahrenheit.	5		
oin Dona		ed 4.6. Extreme Weather- nented in part " The priority			

	Image: Temperature (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NONDER.	A. BUILDING:			
	IL6002539		B. WING		C 12/12/2024	
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
OCTOF	S NURSING & REHA	B CENTER 1201 HAN SALEM,	NTHORN ROA IL 62881	D		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
S9999	Continued From pa	age 7	S9999			
	could experience fr related to weather of we rigorously main ventilation and air of In the event of disru- extreme weather, w actions: Cold Wea It is the Policy of (th continuing, safe, an residents in the even becomes non-oper and furnace system unseasonably cold present and such s resident safety and systems fail. Facilit following action of DON, or Nurse in of response. 2 If the in the facilities own maintenance man	nimize the stress our residents om extreme temperatures events. To mitigate this risk, tain our systems of heating, conditioning and generator uption to these systems during ve will initiate the following ather Policy and Procedure ne facility) to provide nd comfortable care of his ent the facility power source ational or the facility heating ns fail during periods of outside temperatures are systems are required for comfort. If the facility heating y personnel shall take the 1. Either the Administrator, tharge will coordinate the e problem is determined to be heating systems, the or the Administrator will opriate course of action"				