STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145636	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charleston Rehab & Health CC	716 Eighteenth Street Charleston, IL 61920

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to protect a resident's right to privacy by posting a video of R1 in the facility, on social media. The facility also failed to protect a resident's right to privacy during wound care for R10. This failure affects two of five residents (R1 and R10) reviewed for privacy on the sample list on 17. Findings include: 1.) R1's most recent Diagnoses Sheet documents the following: Other, Alzheimer's Disease, Cognitive Communication Deficit, Parkinson's Disease Without Dyskinesia, and Generalized Anxiety Disorder. R1's Minimum Data Set (MDS) dated [DATE] documents the following: R1 had severe cognitive impairment, uses a wheelchair, and is dependent on staff for mobility. On 4/3/25 at 4:55 pm V3, Assistant Director of Nursing (ADON) stated (V12, Licensed Practical Nurse/LPN) alerted me that there was a video on social media of (R1). (V12, LPN had it on her phone. It was of two Agency CNA's (Certified Nursing Assistants), (V6, CNA) and (V7, CNA) who were with (R1). (V6, CNA) had sent it (the video) to (V12, LPN), I guess. The video was old, and we didn't have anything on the facility cameras. I reported this to (V1, Interim Administrator/ Regional Director of Operations/Abuse Prevention Coordinator), immediately. We filed a police report. I knew right off it was at least a privacy issue, and maybe abuse. (V6) and (V7) were both DNR's (Do not return) and the (Private Nurse Staffing) agency was contacted and given the information. On 4/4/25 at 2:55 pm V12, LPN stated I am the one that reported (R1's) situation. So, I was just on (social meeting site) and clicked on an Agency CNA's (V7's) story. There was a video of (R1) and (V7). I was standing next to a different CNA, (V17). We were at work and were on break. I showed the video to her (V17, CNA). We both agreed it needed to be reported. I reported it as soon as we saw it. It was on a Saturday or Sunday. I reported to (V3, ADON) because she was the on-call nurse at the time. The facility's undated Health Insurance Portability and Accountability Act (HIPPA) protocol documents the following: (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	We try to give our residents the best healthcare. Part of our job of caring for them is to keep their health information private. Of course, we all have been told this before. Our employee handbooks talks about privacy and our Corporate Compliance Plans talks about it in the Code of Ethics. And we are reminded by supervisors now and then about how important each resident's privacy is and how we shouldn't discuss their personal health information with others who don't need to know. But now, there is a new law that makes it a crime if we break that new law. And the punishment is big. Up to $250,000 or jail for ten (10) years. The same protocol documents: Social Media, Investigations. The table below provides examples of prohibited activity that would necessitate an investigation by the Community (Nursing Home). Prohibited Activity Unauthorized disclosure of resident information on Internet sites that violate the Health Insurance Portability and Accountability Act (HIPAA), resident rights, and Community policies. Release of non-public financial, operational, and legal information. Information, in the context of their work environment, regarding clients, residents, or other team members, including names, photos, or related information of any kind that violates privacy standards. Engaging in any conduct, activities, communication or posting, that violates Company policies regarding discrimination and other unlawful harassment. 2.) R10's MDS dated [DATE] documents R10's Brief Interview of Mental Status score as 13/15, indicating no cognitive impairment. R10's current Diagnoses sheet documents the following: Cellulitis of Right Lower Limb, Cellulitis of Left Lower Limb, Lymphedema Not Elsewhere Classified, and Need With Personal Care. R10's current Physician Order Sheet documents the following: Gently clean to remove any loose areas; Apply a generous amount of lotion to the area for hydration; elevate lower extremities as tolerated, every shift for bilateral Lymphedema. R10's Care Plan dated 3/14/25 documents the following: The resident has actual impairment to skin integrity r/t (related to) bilateral lower leg Cellulitis and Lymphedema. Interventions (include): (R10) has severe dryness and scaling of both lower extremities. Monitor and report to the Provider (unidentified) condition updates. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/09/25 at 11:45 am R10 was seated in a wheelchair at the center of her room, with her pants rolled up to mid-thigh. R10's bedroom door was wide open. R10's bare legs and feet were in clear view, of multiple unidentified residents and multiple unidentified staff members who were going to the dining room for lunch. R10 had plus-three pitting edema, with large, crusted, yellow scab-like skin scales, from the middle of her lower legs down to the edges of the plantar aspect of her feet, including her toes. The dried yellow crusted scab-like scales of skin flaked off in chunks onto the floor, under her feet, as well as under the wheelchair and surrounding areas. The floor was soiled with the skin debris that extended a two feet wide floor space, around her wheelchair. V49, LPN cleansed each leg with four-by-four gauze and wound cleanser. V49, LPN did one swipe for each section used one four by four gauze pad and wound cleaner, for each section front, back and sides. Skin debris flew in different directions with each swipe of R10's legs. V49, LPN then used dry gauze pads in the same fashion. Each swipe with the gauze pads knocked off a large amount of yellow crusted skin, that flew off her legs and onto to the floor. There was nothing under resident feet to catch any of the scab-like skin debris. V49, LPN completed R10's wound treatment with the door wide open, and R10's bare legs and debris on the floor, in clear view of residents, visitors and staff walking past R10's room. On 4/9/25 at 12:05 pm R10 stated I wear long pants to cover my legs and feet when I leave my room. I don't like to look at the scales on my legs and feet, and I am embarrassed to have others see my gross legs. It is not contagious but other residents don't know that. It also is not very appetizing when I go out to the dining room. Of course, I prefer privacy when the nurses do (complete) my legs (treatment). At least they do the treatments each day. I will take what I can get. My legs itch something terrible. I don't want to scratch them in the dining room and have all that stuff fall off. That would be embarrassing too. They itch until the nurses can get to the treatment. I don't scratch my legs so much then. On 4/9/25 at 12:10 pm V49, LPN stated I was just nervous. I know the residents are supposed to have privacy during all care. The Resident's Right for People in Long-Term Care pamphlet dated November 2018 documents the following: You have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observations, interviews and record review, the facility failed to protect the resident's right to be free from mental abuse of (R1) by V6 and V7, Agency Certified Nursing Assistants (CNA's). This failure affected one of four residents (R1) reviewed for abuse on the sample list of 17. Findings include: R1's most recent Diagnoses Sheet documents the following: Other, Alzheimer's Disease, Cognitive Communication Deficit, Parkinson's Disease Without Dyskinesia, and Generalized Anxiety Disorder. R1's Minimum Data Set (MDS) dated [DATE] documents the following: R1 had severe cognitive impairment, uses a wheelchair, and is dependent on staff for mobility. The facility email to Illinois Department of Public Health Final Report dated [DATE] documents: It was reported to leadership on [DATE] at 1:35 pm, a video was on social media showing inappropriate engagement with a resident, with 2 (two) agency CNA's (V7 and V8, Certified Nursing Assistants) from (Nurse Staffing Agency). The CNA's involved from (Nurse Staffing Agency), (V6) and (V7), were not on duty at the time of the allegation (was reported). Both CNAs were DNR (Do Not Return) from (Nurse Staffing Agency). Following review of the video and statements provided by both suspended CNAs, and other (facility name) staff, the exact date of the video could not be determined. It was stated by (V7, CNA) the video was several months old. The alleged behaviors depicted in the video were confirmed to have occurred. The video depicted a CNA, (V7), locking a wheelchair (R1) was sitting in, and telling him 'you gotta move quicker than that'. As (R1) attempted to unlock the chair, the aide (V7, CNA) relocked the wheelchair. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:55 pm V12, Licensed Practical Nurse stated I am the one that reported (R1's) situation. So, I was just on (specified social meeting site) and clicked on an Agency CNA (V7's) story. There was a video of (R1) and (V7). I was standing next to a different CNA, (V17). We were at work and were on break. I showed the video to her (V17, CNA). We both agreed it needed to be reported. I reported it as soon as we saw it. It was a Saturday or Sunday. I reported to (V3, Assistant Director of Nursing) because she was the on-call nurse at the time. V12 also stated The video looked to me like the CNA's (V6 and V7) were antagonizing him. They were going up to wheelchair, and it looked like the person recording, I assume was (V6, CNA), and (V7, CNA) were tapping on each side of his wheelchair and locking it, repeatedly. It appeared their intention was to cause mental harm towards him. He looked very upset, and very anxious. (R1) had (deceased on hospice) dementia and probably did not understand what was going on. I do believe he looked very anxious, very confused. He did have a diagnosis of Anxiety, but this was much different. I believe it was the circumstances that lead to him being more anxious. There we no other staff or residents in the video. It looked like it was taken near scale on [NAME] Hall. The video was maybe fifteen seconds or I should say less than a minute. It was hard to watch. He was in distress for the entire length of the video. They were absolutely abusive toward him. When I worked after reporting the video, (R1) was always at his baseline. His normal anxiety. (V7) was in the video. (V6,) was the one that posted it the first time. (V7) re-posted it. It posts her (V7) name on the post, when something is being re-posted. That specific story was up for 24 hours, then it disappears (on specific social media site). I could not see (V6's) post, because we aren't friends on (social media site) and (V7) and I are. It could have been on their phone, months before it was posted. There is really no way to know when the video was recorded. On [DATE] at 3:15 pm, during observation of the corner that R1's wheelchair was parked at the time of the mental abuse, V17, Certified Nursing Assistant (CNA) stated I was here when (V12, Licensed Practical Nurse/LPN), the nurse on the hall I was working saw the video on (social media site) with (R1) in it. She (V12, LPN) showed it to me. I saw (R1) seated in his wheelchair, one person was videotaping, I believe it was (V6, CNA) taping. While (V6) videotaped, (V7, CNA) was aggravating (R1). She (V7, CNA) was obviously taunting him (R1). All you could hear of the video was (V7, CNA) saying 'You have to be quicker than that.' (V7, CNA) reached down to lock his wheelchair. (R1) went to grab her arm. He didn't grab it though. He looked aggravated and mad. He couldn't do anything. (V7, CNA) was standing in front of his (R1's) wheelchair. He could not go anywhere, once she locked his wheelchair brakes. Over and over as he (R1) tried to release them. (V7, CNA) would re-lock them. He was in this corner (V17, points to a corner, on [NAME] hall, across from the scale, where R1 would have faced a blank wall with coat hooks on it). (R1's) facial expression showed he was mad. He was fidgeting and trying to stand. He was a fall risk and can't really stand on his own. It was a short video, maybe 30 seconds. It was mentally abusive. (V2, Director of Nursing) was the on-call nurse supervisor. We reported to her. (V12, LPN) and we both agreed to report it as abuse for taunting him (R1) and posting the picture on (social media). On [DATE] at 2:40 pm V1, Interim Administrator/Abuse Prevention Coordinator/Regional Director of Operations stated he viewed the video of R1, which had been posted on social media. It was terrible. Clearly mental abuse. V1 also stated V1 hopes the perpetrators, V6 and V7, will have their certification revoked. V1 also stated the CNA's have no business working with this vulnerable population. The facility ABUSE, PREVENTION AND PROHIBITION POLICY dated ,d+[DATE] documents the following: STATEMENT OF INTENT (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. POLICY This facility prohibits mistreatment, neglect, or abuse of residents. This 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. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property. The residents must not be subjected to abuse by anyone. The facility will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including definitions pertaining to abuse and neglect. Annually, the Administrator will contact local law enforcement to review the requirements for reporting to law enforcement. Definitions: Abuse - means 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. Instances of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Technology includes any type of video or voice recording of residents, taking pictures of residents, or social media posts, unless by an authorized individual. Mental Abuse includes but is not limited to, humiliation, harassment, and threats of punishment or deprivation. Mental abuse includes but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on record review and interview the facility failed to maintain a professional standard of conduct, by working under the influence of alcohol. This failure had the potential to affect all 54 residents that reside in the facility. Findings include: V5, Previous Administrator EMPLOYEE CORRECTIVE ACTION FORM documents the date of offense occurred 02/18/25. The same form documents: Offense: Category I (Gross Misconduct - Immediate Discharge) Failure to follow appropriate policies or procedures that results in harm/potential harm to a team member, resident, or visitor. The same form documents: On 2/20/25, admitted to consuming alcoholic beverages on 2/18/2025, a few hours before entering the community (facility), conducting a brief round. allowing 2 (two) clinical team members, who also consumed alcohol, to conduct skills checks with staff and assist with opening a Stat Safe for a medication. V3, Assistant Director of Nursing (ADON) EMPLOYEE CORRECTIVE ACTION FORM documents the date of offense occurred 02/18/25. The same form documents: Offense: Category II (Misconduct) Third Offense (Final Warning). The same form documents: Identify work rule/policy # and description from the Employee Handbook #25 - Other instances of improper conduct not specifically listed. On 2/20/25, admitted to consuming alcoholic beverages on 2/18/2025, a few hours before entering the community and performing clinical duties. Action: Progressive Corrective Action: Subsequent violation(s) in a specific category will result in further corrective action - up to and including discharge. Three write-ups in a specific category over a 12-month period will result in discharge. V3, ADON signed the EMPLOYEE CORRECTIVE ACTION FORM I agree with the facility's determination. V4, Restorative Certified Nursing Assistants (CNA) EMPLOYEE CORRECTIVE ACTION FORM documents the date of offense occurred 02/18/25. Offense: Category II (Misconduct) Third Offense (Final Warning). (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The same form documents: Identify work rule/policy # and description from the Employee Handbook #25 - Other instances of improper conduct not specifically listed. On 2/20/25, admitted to consuming alcoholic beverages on 2/18/2025, a few hours before entering the community and performing clinical duties.V4, Restorative CNA signed the EMPLOYEE CORRECTIVE ACTION FORM, I agree with the facility's determination. The facility investigation related to the above 2/18/25, employee corrective action documents the following witness statement, written by V1, Interim Administrator/Regional Director of Operations of V1's interview with V2, Director of Nursing (DON). (V3, ADON), (V4, Restorative CNA), (V5, Previous Administrator) and (V29, Administrator sister facility) met me (V2, DON) at a local establishment for pizza around 5:30 pm. No alcohol was consumed at the dinner. We (V2, V3, V4, V5 and V29) then went to a local bar/restaurant around 6:30 pm to play trivia which started around 7:00 pm. I would say more than one drink was consumed by (V3, V4, and V5). I left the establishment with my fiance to go home around 9:15p-9:30p. Neither (V5, V4, of V3) mentioned anything about planning to come to the building. I did not hear anything more from them the rest of the night. The facility investigation related to the above 2/18/25, employee corrective action documents the following witness statement, written by V1, Interim Administrator/Regional Director of Operations of V1's interview with V22, CNA, I came into work around 9:45 pm. Around 10 pm (V3, ADON), (V5, Previous Administrator) and (V4, Restorative CNA) came into the building. (V4) watched me do catheter care on (R12). No other team members were in the room. I also took some PTO (Paid Time Off) request forms to (V3, ADON). (V3, V5 and V4) were here for around 30 minutes. (V4's) eyes were glassy, and face was rosy, and she was acting a bit hyper. I witnessed (V4) run to a staff member and give them a big hug. It was (V25, Licensed Practical Nurse). I did not smell any alcohol on (V4). I overheard (V3, ADON) talking about (V4, Restorative CNA) taking tequila shots at the bar that night. (V3, ADON) appeared to be rosy in the face. I did not smell alcohol on anyone. (V4) was with (V20, CNA) before I did my skills check with her. (V5, Previous Administrator), called me on Wednesday morning at approximately 7:25 am asking why I told another staff member that (V3), (V5) and (V4) were in the building after drinking. I heard from other staff members there were pictures on (social media) of them at the bar but I have not seen them. On 4/3/25 at 4:55 pm V3, Assisted Director of Nursing confirmed she had come into the building 2/18/25 about 10:00 pm, with V4, Restorative CNA, and V5 Previous Administrator, after having a couple drinks V3, also stated We should not have come in after drinking. What happened, happened. No one got hurt. On 4/4/25 at 2:20 pm V4, Restorative Certified Nursing Assistant confirmed she had consumed alcohol on 2/18/25, before coming into the facility. V4 acknowledged she observe CNA's completing resident care as part of their skills check, that night shift. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/8/25 at 2:13 pm V22, CNA stated (V4, Restorative CNA) was being loud the night her (V4), (V3, Assistant Director of Nursing) and (V5, Previous Administrator) came in after drinking. She was not loud in the residents' rooms, it was close to the end of the resident hall. It was close to the circle, where all the offices are, and the halls meet. (V4) was being loud and ran through the circle to hug (V25, LPN). I did catheter care on (R12). (V4) was there to observe and check off my skills. I don't know who else she (V4) watched. I know she was not disruptive in (R12's). Her face was real red, and her eyes were glassy. She was not hyped up in his room, like she was in the center (hallway corridor), by the offices. (V3, ADON)'s face was really red too. I did not smell alcohol on them, or (V5) the Administrator at the time. I was surprised they came in her after drinking. I heard (V3) and (V4) talking about doing tequila shots. That is about it. I don't know who else had skill checks that night. (V20) is a CNA that was here. (V4) may have watched her do care. I don't know. The facility Matrix 802 dated 4/03/25 documents 54 residents reside in the facility. The Facility assessment dated [DATE] documents, in part, the following: Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. Staff Type: Administration (Administrator, Business Office Manager) Nursing Services (DON, RCC, Infectious Preventionist, RNs, LPNs, Care Plan Coordinator, CNAs, Unity Aides)