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	09/02/2025

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

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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 the dignity of one (R8) resident out of three residents reviewed for resident rights in a sample list of 17 residents. Findings include: R8's Minimum Data Set (MDS) dated [DATE] documents R8 as cognitively intact. R8's Nurse Progress Note dated 8/17/2025 at 12:24 PM documents R8 was crying, stating staff was not listening, laughing at her (R8) and stated she (R8) wanted to leave Against Medical Advice (AMA). On 8/27/25 at 10:00 AM, R8 stated on 8/13/25 she was worried about R9 since R8 heard R9 screaming so loud. R8 stated she got herself up into her motorized wheelchair and went out to the hall. R8 stated V2 Director of Nursing (DON) was yelling and laughing at her (R8) because she was concerned about R9. R8 stated R8 had an abscessed tooth on the upper Left back side in her mouth. R8 stated she woke up one day (8/17/25) and 'the whole Left side of my face was swollen out to here' (pointing to Left cheek area). R8 stated R8 was telling the staff (V2 DON, V14 LPN and V20 LPN) about this and the staff yelled and laughed at her. R8 stated 'They (staff) were all laughing at me. It made me feel so sad.' On 8/27/25 at 1:50 PM, V1 Administrator stated staff should always treat residents with dignity and respect. V1 stated the staff should be more aware of residents. V1 stated R8 was not abused but the staff should be more aware of their conversations when residents are within earshot. The facility policy approved December 2024 documents each resident in this community has the right and will be afforded the right to a dignified existence, self-determination, and communications with and access to persons and services inside and outside the community without interference, coercion, discrimination or reprisal. No staff member or contracted provider of care will hamper, compel, treat differently or retaliate against a resident for exercising Resident Rights.

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

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	09/02/2025

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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** Based on interview and record review the facility failed to protect the rights of the residents to be free from verbal/emotional abuse from staff and other residents. This failure affected seven of eight residents (R2, R4, R5, R6, R7, R9, R13) reviewed for abuse on the sample list of 17. Findings Include: 1. R2's Medical Diagnosis List dated August 2025 documents R2 is diagnosed with Epilepsy. R2's Care Plan dated 7/26/25 documents R2 has a diagnosis of Seizure Disorder. Staff are to administer medications, protect from onlookers, provide post seizure treatment, and take vital signs and do neuro checks post seizure. R2's Minimum Data Set, dated [DATE] documents R2 is cognitively intact. On 8/29/25 at 12:15 PM, R2 stated V13 Licensed Practical Nurse (LPN) often tells others that he is faking his seizures. R2 stated this makes him feel upset and mad. R2 stated he (R2) does not fake his seizures, and it is embarrassing that the nurse doesn't believe that he (R2) is dealing with seizures. R2 stated he believes V13 hates his guts. R2 stated he is not stupid, and he knows V13 doesn't really care about him. The Incident Report Investigation dated 8/4/25 documents on 8/4/25 R2 alleged abuse by V13 Licensed Practical Nurse (LPN). On 8/29/25 at 10:34 AM, V9 Certified Nurse Assistant (CNA) stated on 8/4/25, she walked up to the nurse's station, R2 was sitting in a chair behind where V13 was standing. V13 Licensed Practical Nurse (LPN) asked V9 to get R2's vital signs because R2 was having a seizure, and his arms were shaking and moving. R2's head was down, and he was not responding. V9 stated V13 LPN turned around and bent down in front of R2. V13 picked up R2's head and opened his eyelid. V9 stated at that point V13 said R2 was fine, and he was faking it and if you look at his pupils you can tell. V13 claimed R2 was faking his seizures and repeated these many times in front of R2. On 8/29/25 at 12:40 PM, V1 Administrator confirmed staff should never be accuse a resident of faking a seizure. V1 confirmed this could be very upsetting for R2 and could be considered emotional abuse. 2. R4's Medical Diagnosis List dated August 2025 documents R4 is diagnosed with Neurocognitive Disorder with Lewy Bodies and Dementia with Psychotic Disturbance. R4's Care Plan dated 8/29/25 documents R4 has behavior concerns related to aggression towards staff and other residents. R4 is at risk for wandering. R4's Minimum Data Set, dated [DATE] documents R4 is severely cognitively impaired. 3. R5's Medical Diagnosis List dated August 2025 documents R5 is diagnosed with Surgical Aftercare for Left Femur Fracture. (continued on next page)

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	145636	A. Building B. Wing	09/02/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Minimum Data Set, dated [DATE] documents R2 is cognitively intact. On 8/27/25 at 2:31, PM V11 Certified Nurse's Assistant (CNA) stated on 7/22/25 she was standing at the nurse's station when she heard R5 yell for someone to get out of her room. V11 stated she began to walk towards R5 and entered R5's room. R4 was in R5's room and R5 was telling R4 to get out. R4 responded by telling R5 she would whoop her a** (expletive). R5 responded by calling R4 a wench. On 8/29/25 at 12:40 PM, V1 Administrator confirmed R4 and R5 had a verbal altercation and required separation from staff. V1 confirmed the altercation could be considered verbal abuse. 4. R6's Medical Diagnosis List dated August 2025 documents R6 is diagnosed with Panic Disorder, Mild Cognitive Impairment, Psychotic Disturbance, Mood Disorder, and Anxiety. R6's Care Plan dated 7/3/25 documents R6 has a diagnoses of impaired cognitive function/dementia or impaired thought processes. R6's Minimum Data Set, dated [DATE] documents R6 is moderately cognitively impaired. The Incident Report Investigation dated 7/6/25 documents alleged abuse occurred involving V3 CNA and R6. On 8/27/25 at 2:31 PM, V11 Certified Nurse Assistant (CNA) stated R6 does not enjoy eating in the dining room and if she does agree to eat in the dining room, she likes to leave right after she is done eating. V11 stated on 7/6/25 V3 Certified Nurse's Assistant entered the dining room directly after R6 had finished eating and was about to leave the dining room. V3 proceeded to stop R6 from exiting and attempted to feed R6 more food. R6 refused and began to get agitated however V3 continued to agitate R6 and would not allow R6 to leave the dining room. V11 stated it seemed as though V3 wanted to agitate R6 and was trying to get a reaction from her. V11 stated she got up and attempted to help R6 move away from V3 however V3 told V11 that R6 could not leave and needed to stay in the dining room until everyone else was done eating. V11 stated at that moment V10 CNA approached R6 and told her she was needed in her room for an intravenous treatment. V3 then began to laugh and got up in R6's face and said, “Haha, you have to go get poked”. V11 stated R6 appeared visibly upset and irritated. V11 confirmed she believes V3 was mentally abusive to R6 by being intimidating and controlling. On 8/29/25 at 10:14 AM, V10 CNA stated on 7/6/25 she went to retrieve R6 from the dining room for an intravenous treatment. When V10 approached R6, V3 stated R6 needed to stay in the dining room until everyone else was done eating. V10 stated V3 had her feet up on R6's wheelchair as if she was keeping her there. V10 stated V3 was being very rude and when V10 told them why she was taking R6 to her room, V3 replied by getting inches away from R6's face and saying, “Haha, you have to go get poked”. V10 confirmed she believes this could be considered mental or emotionally abusive behavior by V3. On 8/29/25 at 12:40 PM, V1 Administrator confirmed V3 was suspended pending an investigation related to her mistreatment of R6. After the investigation it was determined V3 would be terminated. V1 confirmed the facility does not tolerate resident mistreatment. (continued on next page)

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	145636	A. Building B. Wing	09/02/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. R7's Medical Diagnosis List dated August 2025 documents R7 is diagnosed with Dementia with Behavioral Disturbances, Repeated Falls, Parkinson's Disease, Unsteadiness on Feet, and Need for Assistance with Personal Care. R7's Care Plan dated 7/3/25 documents R7 requires assistance with Activities of Daily Living and Self Care related to a self-care deficit. R7's Minimum Data Set, dated [DATE] documents R7 is severely cognitively impaired. The Incident Report Investigation dated 7/6/25 documents alleged abuse occurred involving V3 CNA and R7. On 8/29/25 at 10:34 AM, V9 Certified Nurse Assistant (CNA) stated on 7/6/25 she assisted R7 to the bathroom. V9 stated R7 seemed a bit more tired than usual so she asked for help from another CNA V3. V3 laughed in V9's face and asked why V9 toileted R7. V9 stated she always toilets R7 before bed. V3 came over to provide physical assistance and V9 and V3 assisted R7 in standing up. V9 stated R7 is slow moving, and V3 did not want to wait for him to move so she shoved him over to turn his hips so he could sit down. V9 stated she told V3 that she didn't want R7 to fall, and V3 replied she didn't give a f*** (expletive) if he falls because she won't get in trouble anyway. V9 stated V3 said this in front of R7. V9 confirmed this could be considered abuse. On 8/29/25 at 12:40 PM, V1 Administrator confirmed V3 was suspended pending an investigation related to her mistreatment of R7. After the investigation it was determined V3 would be terminated. V1 confirmed the facility does not tolerate resident mistreatment. The Employee Corrective Action Form dated 7/6/25 documents V3 was terminated for cursing near residents and providing discourteous care of residents. 6. R13's undated Face Sheet documents medical diagnoses as Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant side, Anxiety Disorder, Paroxysmal Tachycardia, Atrial Fibrillation, History of Falling and Dependence on Wheelchair. R13's Minimum Data Set (MDS) dated [DATE] documents R13 as cognitively intact. This same MDS documents R13 as requiring supervision with eating, maximum assistance with bathing, dressing, personal hygiene, bed mobility and is dependent on staff for toileting. R9's Minimum Data Set (MDS) dated [DATE] documents R9 as severely cognitively impaired. This same MDS documents R9 requires supervision with eating and moderate assistance with transfers. R13's Initial Report to the State Agency dated 8/14/25 documents R9 cursed at R13 on 8/14/25. On 8/29/25 at 1:25 PM, R13 stated he resides on the same hall as R9. R13 stated the morning of 8/14/25 R9 was in the dining room ‘yelling and cussing at everyone'. R13 stated R9 then passed R13 in the hallway and R9 yelled ‘Stupid B****' (expletive) at R13. R13 stated R9 called him other curse words that morning and at other times also. R13 stated R13 is not afraid of R9 but does not like to be called bad names. R13 stated R9 also called R13 a ‘stupid b******' (expletive) that same morning. (continued on next page)

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	145636	A. Building B. Wing	09/02/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/25 at 1:36 PM, V16 Certified Nurse Assistant (CNA) stated R9 cursed at R13 the morning of 8/14/25. V16 CNA stated R9 was having behaviors that morning when R9 was in the hallway as R13 yelled curse words at R9. On 8/29/25 at 11:00 AM, V1 Administrator stated R9 is known to have violent outbursts with yelling, cursing and throwing items. V1 Administrator stated on 8/14/25, R9 was upset because his pencil sharpener was missing. V1 Administrator stated R9 yells out regardless of who is around. V1 Administrator stated that morning (8/14/25) R9 intentionally yelled curse words at R13. The facility policy titled Abuse, Prevention & Prohibition Policy approved December 2024 documents 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. The facility Administrator will be designated as the facility Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation. If the Administrator is not available to address this role, the Administrator will designate a person “in charge” in their absence to fulfill the role. This person would normally be the Director of Nursing. Resident to resident abuse includes the term “willful”. The work “willful” means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within the hearing distance regardless of their age, ability to comprehend, or disability. 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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	145636	A. Building B. Wing	09/02/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report allegations of mental abuse on two separate occasions affecting one (R8) resident from staff interactions to the State Agency timely out of three residents reviewed for Abuse in a sample list of 17 residents. Findings include:R8's Minimum Data Set (MDS) dated [DATE] documents R8 as cognitively intact. R8's Nurse Progress Note dated 8/17/2025 at 12:24 PM documents R8 was crying, stating staff was not listening, laughing at her and states she wanted to leave Against Medical Advice (AMA). On 8/26/25 at 12:10 PM, V1 Administrator was informed of an allegation of mental abuse of R8 from staff V2 Director of Nursing (DON), V14 Licensed Practical Nurse (LPN) and V20 LPN on 8/13/25. V1 stated this allegation was never reported to the State Agency. On 8/27/25 at 1:40 PM, V1 Administrator stated she was not made aware of R8's allegation of mental abuse from staff on 8/13/25 nor 8/17/25. V1 stated she was made aware through her own record review of R8 on 8/27/25. V1 Administrator stated staff should always report any allegation of abuse directly to the Administrator. The facility policy titled Abuse, Prevention & Prohibition Policy approved December 2024 documents 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. The facility Administrator will be designated as the facility Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation. If the Administrator is not available to address this role, the Administrator will designate a person in charge in their absence to fulfill the role. This person would normally be the Director of Nursing. Resident abuse must be reported immediately to the Administrator. The Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action.

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	145636	A. Building B. Wing	09/02/2025

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	145636	A. Building B. Wing	09/02/2025

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess, provide timely treatment, provide complete urinary catheter care, prevent cross contamination during wound care for one (R10) resident out of four residents reviewed for Urinary Tract Infections (UTI) in a sample list of 17 residents. These failures resulted in R10 obtained a Penile wound at facility which caused pain, additional medicated treatment and additional specialty physician appointments. Findings include:R10's undated Face Sheet documents R10 admitted to the facility on [DATE] with medical diagnoses documented as Metabolic Encephalopathy, Chronic Heart Failure, Muscle Wasting and Atrophy, Need for Assistance for Personal Care, Chronic Kidney Disease, Morbid Obesity, Infection and Inflammatory Reaction due to Indwelling Urethral Catheter, Alzheimer's Disease, Obstructive and Reflux Uropathy, Retention of Urine and Urinary Tract Infection (UTI). R10's Minimum Data Set (MDS) dated [DATE] documents R10 as moderately cognitively impaired. This same MDS documents R10 requires moderate assistance with bathing, personal hygiene, transfer, maximum assistance with dressing and is dependent on staff for toileting. R10's Care Plan revised 1/6/2025 instructs staff to anchor indwelling catheter tubing high on R10's thigh to reduce pulling/tethering on the penis. R10's catheter should not be pulled tight. This same care plan documents R10 has redness on the tip of penis. Staff will monitor and inform wound care of skin.R10's Physician Order Sheet (POS) dated July 2025, and August 2025 documents a physician order starting 7/25/25 to apply Zinc cream to R10's penis twice a day. R10's Skin Sweep assessment dated [DATE] documents No Findings. R10's Nurse Progress Note dated 6/30/25 at 6:47 AM documents R10's head of Penis was red and excoriated with no drainage. This note documents wound nurse was notified of reddened area. R10's Nurse Progress Note dated 7/15/25 at 1:49 PM documents R10 complained of pain to his Penis. This note documents R10's head of Penis was excoriated. This note documents wound nurse was notified of reddened area. R10's Urology Progress Note dated 7/16/25 documents (R10's) Catheter NOT anchored!! Catheter changed and anchored to (R10) thigh. Make sure (catheter) is anchored properly to (R10) thigh. R10's Shower Sheet dated 7/22/25 documents R10's perineal area is red. This same sheet documents R10 complained of his perineal area as 'itchy'. R10's Shower Sheet dated 7/24/25 documents R10 was Bleeding from Penis at catheter site. This same shower sheet documents R10 was complaining of bleeding in his urinary incontinence brief and in 'lots of' pain. R10's Nurse Progress Note dated 7/24/25 at 4:27 PM documents R10's tip of Penis was reddened. This same note documents an order for Zinc was requested. R10's Weekly Skin Check dated 7/26/25 documents R10 has excoriation to his Penis. This same skin check does not include measurement, drainage, nor assessment of wound.R10's Shower Sheet dated 7/29/25 documents R10 was complaining of irritation at the head of his Penis. R10's Nurse Progress Notes dated 8/16/25 at 4:33 PM, 8/17/25 at 1:02 AM, 8/17/25 at 5:22 PM and 8/18/25 at 5:24 AM documents R10's physician ordered Zinc cream was not available to apply to R10's Penile wound. On 8/27/25 at 11:35 AM, V16 Certified Nurse Assistant (CNA) completed indwelling urinary catheter care and perineal care for R10. V16 CNA did not fully retract R10's Penile Foreskin when cleaning R10's Perineal area. R10's proximal head of his Penis was red, open with a small amount of bleeding. R10's indwelling urinary catheter was not secured to prevent tethering. On 8/27/25 at 11:50 AM V17 Registered Nurse (RN) completed R10's Penile wound treatment. V17 RN did not change gloves nor perform hand hygiene between cleansing R10's Penile wound and applying R10's prescribed Zinc cream. V17 RN did not fully retract R10's Penile Foreskin to fully expose R10's filleted Penile wound. V17 RN applied R10's Zinc cream with contaminated glove used to cleanse blood from R10's filleted Penile wound. On 8/27/25 at 12:10 PM, V16 Certified Nurse Assistant (CNA) stated she did not fully retract R10's Penile Foreskin for cleansing due to R10's filleted Penile wound was bleeding. V16 CNA stated R10's entire area should have been cleansed including underneath R10's Penile Foreskin.On 8/27/25 at 12:15 PM, V17 Registered Nurse (RN) stated she forgot to wash her hands after cleansing R10's fillet Penile wound and prior to applying R10's Zinc treatment. V17 RN stated she should have not used her gloves to apply R10's cream. V17 RN stated she was unable to see R10's entire filleting of R10's Penis due to she did not fully retract R10's Penile Foreskin. On 8/29/25 at 1:40 PM, V2 Director of Nursing (DON) stated R10 did not admit to the facility with any Penile wounds. V2 DON stated R10 should have his catheter secured at all times to prevent tethering. V2 DON stated R10's Penile wound is directly caused by the constant pulling of his urinary catheter. V2 DON stated there is no reason the facility should be out of a commonly product such as Zinc Oxide. V2 DON stated

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	145636	A. Building B. Wing	09/02/2025

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to effectively supervise an unalarmed and unlocked facility exit door. This failure resulted in R3, a resident with a diagnosis of Dementia, eloping unnoticed from the facility and exiting through the facility courtyard towards the facility parking lot area. The facility also failed to identify and document any root-cause for R3's elopement in their elopement investigation. R3 is one of three residents reviewed for supervision in the sample of 17. Findings include: R3's Medical Diagnosis sheet (8/27/2025) documents R3's diagnoses including Dementia, Weakness, Muscle Wasting and Atrophy, and Unsteadiness on Feet. R3's Orders sheet (8/27/2025) documents the order May be up ad-lib (at liberty) per plan of care. R3's Elopement Assessment (6/4/2025) documents R3 is cognitively impaired, independently mobile, and has the elopement risk factor of a recent mental status change. R3's Resident Assessment (6/10/2025) documents R3 has severe cognitive impairment.R3's Care Plan (8/27/2025) documents R3 only requires a minimal level of staff assistance as needed for ambulation. The facility incident report (8/8/2025) documents V5 (Certified Nursing Assistant) noticed R3 walking on a sidewalk outside of the facility on 8/2/2025 and retrieved R3 back into the facility and to R3's bedroom. On 8/27/2025 at 1:45PM, V5 reported being in R15's room on 8/2/2025 providing care to R15 and when V5 looked through R15's window, R3 was visible outside of the facility walking down a sidewalk along the side of the building with R3's walker. V5 reported immediately going outside to retrieve R3 back inside of the facility with R3 stating to V5 at the time it's a beautiful day outside and I just got turned around and need to go home. V5 reported turning R3 around to go back into the facility and R3 then stated Oh, there's my home. V5 denied any door alarms were sounding when R3 eloped from the facility. V5 reported R3 must have exited the building through an exit door located in the hallway near R3's room leading to a courtyard and then out of the courtyard to the sidewalk where V5 found R3. V5 reported the courtyard has a swinging gate that leads to a sidewalk located along the exterior building perimeter and the gate was unlocked and open the day R3 eloped due to the facility mowing contractor being in and out of the courtyard area to [NAME] grass. V3 reported R3 ambulates independently and R3's cognition is so-so and hit or miss. V5 reported the hallway exit door to the courtyard was always kept unlocked and unalarmed so residents who smoke independently could access the facility smoking area located inside of the courtyard without staff supervision. On 8/29/2025 at 10:48AM, the swinging gate leading from the above courtyard to the sidewalk and building exterior was closed but unlocked and easily opened by the surveyor. The facility Elopement policy (June 2025) documents It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible and Should an elopement occur, the facility's QAPI Committee shall determine the root cause of the elopement and review the facility's systems, policies and procedures, and responses to elopements to identify areas of opportunity for improvement.The facility's Elopement investigation related to R3's 8/2/2025 elopement does not identify or document any root cause for R3's elopement occurring on 8/2/2025 and does not document the hallway exit door above was unsupervised, unlocked, and unalarmed when R3 eloped from the facility. The same investigation fails to document the courtyard exit gate was unlocked at the time of R3's elopement.

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	09/02/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document a resident (R3) elopement and subsequent investigation in the resident's medical record. This failure affects one resident (R3) of three reviewed for elopement in the sample of 17.Findings include:R3's Medical Diagnosis sheet (8/27/2025) documents R3's diagnoses including Dementia, Weakness, Muscle Wasting and Atrophy, and Unsteadiness on Feet. R3's Orders sheet (8/27/2025) documents the order May be up ad-lib (at liberty) per plan of care. R3's Elopement Assessment (6/4/2025) documents R3 is cognitively impaired, independently mobile, and has the elopement risk factor of a recent mental status change.R3's Resident Assessment (6/10/2025) documents R3 has severe cognitive impairment.R3's Care Plan (8/27/2025) documents R3 only requires a minimal level of staff assistance as needed for ambulation.The facility incident report (8/8/2025) documents V5 (Certified Nursing Assistant) noticed R3 walking on a sidewalk outside of the facility on 8/2/2025 and retrieved R3 back into the facility and to R3's bedroom. On 8/27/2025 at 1:45PM, V5 reported being in R15's room on 8/2/2025 providing care to R15 and when V5 looked through R15's window, R3 was visible outside of the facility walking down a sidewalk along the side of the building with R3's walker. V5 reported immediately going outside to retrieve R3 back inside of the facility with R3 stating to V5 at the time it's a beautiful day outside and I just got turned around and need to go home. V5 reported turning R3 around to go back into the facility and R3 then stated Oh, there's my home. V5 denied any door alarms were sounding when R3 eloped from the facility. V5 reported R3 must have exited the building through an exit door located in the hallway near R3's room leading to a courtyard and then out of the courtyard to the sidewalk where V5 found R3. V5 reported the courtyard has a swinging gate that leads to a sidewalk located along the exterior building perimeter and the gate was unlocked and open the day R3 eloped due to the facility mowing contractor being in and out of the courtyard area to [NAME] grass. V3 reported R3 ambulates independently and R3's cognition is so-so and hit or miss. V5 reported the hallway exit door to the courtyard was always kept unlocked and unalarmed so residents who smoke independently could access the facility smoking area located inside of the courtyard without staff supervision. On 8/29/2025 at 10:48AM, the swinging gate leading from the above courtyard to the sidewalk and building exterior was closed but unlocked and easily opened by the surveyor. The facility Elopement policy (June 2025) documents It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible and Should an elopement occur, the facility's QAPI Committee shall determine the root cause of the elopement and review the facility's systems, policies and procedures, and responses to elopements to identify areas of opportunity for improvement.The facility's Elopement investigation related to R3's 8/2/2025 elopement does not identify or document any root cause for R3's elopement occurring on 8/2/2025 and does not document the hallway exit door above was unsupervised, unlocked, and unalarmed when R3 eloped from the facility. The same investigation fails to document the unlocked courtyard exit gate was unlocked at the time of R3's elopement. On 8/29/2025 at 1:23PM, V2 (Director of Nursing) reported being unsure if R3's medical record in the facility documented R3's elopement occurring on 8/2/2025.R3's nursing progress notes (August 2025) do not document R3's elopement.R3's electronic medical record (undated/accessed 9/2/2025) does not document R3's elopement incident on 8/2/2025.On 9/2/2025 at 1:32PM, V2 reported V2 would look again in R3's medical record for documentation of the elopement and V2 reported being unsure if the elopement was documented anywhere except in the Risk section of R3's electronic medical record (a portion of R3's EMR not normally accessible to medical staff or nursing staff).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the proper Personal Protective Equipment (PPE) for one (R8) resident on Enhanced Barrier Precautions (EBP) out of three residents reviewed for Urinary Tract Infections (UTI) in a sample list of 17 residents. Findings include:R8's Minimum Data Set (MDS) dated [DATE] documents R8 as cognitively intact. This same MDS documents R8 as requiring maximum assistance for toileting and moderate assistance for dressing, personal hygiene and bathing.R8's Electronic Medical Record (EMR) documents R8 is on Enhanced Barrier Precautions (EBP) due to R8 having a history of a Multi Drug Resistant Organism (MDRO) and currently has an indwelling urinary catheter. On 8/27/25 at 2:00 PM, V15 and V16 Certified Nurse Assistants (CNA) provided indwelling urinary catheter care and perineal care for R8. R8 had a sign on the wall outside her door next to the floor that read 'Enhanced Barrier Precautions' (EBP). V15 and V16 did not wear gowns when providing direct catheter care and perineal care for R8. V16 CNA emptied R8's urinary drainage bag which contained 450 milliliters (ml) of dark orange, hazy urine without wearing a gown. R8's room did not contain any disposal bins for contaminated Personal Protective Equipment (PPE). R8's garbage cans inside her room did not contain any PPE that had been disposed of. On 8/27/25 at 2:20 PM, V15 and V16 Certified Nurse Assistants (CNA) both stated they should have worn gowns when providing direct cares for R8. V16 CNA stated not wearing the proper PPE could result in cross contamination to other residents. On 8/29/25 at 10:45 AM, V21 Assistant Director of Nursing (ADON)/Infection Preventionist (IP)/Registered Nurse (RN) stated staff should wear the appropriate Personal Protective Equipment (PPE) when providing direct cares such as indwelling urinary catheter care, perineal care and emptying of a resident's urinary drainage bag. V21 stated the purpose behind a resident being placed on EBP is due to that resident has had a history of a Multi Drug Resistant Organism (MDRO) and/or has an indwelling device. V21 stated R8 has both a history of MDRO and has an indwelling urinary catheter. V21 stated R8 is high risk for obtaining another infection which could be spread if the staff do not wear the proper PPE. The undated facility policy titled Infection Prevention and Control Manual-Enhanced Barrier Precautions (EBP) documents EBP involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a Multi Drug Resistant Organism (MDRO) as well as those at increased risk for MDRO acquisition (such as residents that have wounds or indwelling medical devices). High-contact resident care activities where a gown and gloves should be used include providing hygiene, caring for or using an indwelling medical device and performing wound care.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to check their medical equipment on a timely basis to ensure the medical equipment is in good working condition. The failure of maintaining the Automated External Defibrillator (AED) prevented the use of the AED during an episode of Cardiac Failure for one resident (R1) reviewed for Cardiac Failure in a sample of one. Findings include:Progress notes for R1 dated [DATE] at 7:01 PM document R1's return from the hospital to the facility with the diagnosis of Acute Respiratory Failure with Hypoxia. On [DATE] staff was sent to get V25 Registered Nurse (RN) due to R1 having an episode of not breathing and unresponsive. V25 asked staff to take R1 to his room and place him on the bed with the cardiac board behind R1's back and to obtain the cardiac cart due to R1's medical status. On [DATE] at 9:56 AM, return call from V25 RN (Registered Nurse) was received and V25 stated R1 's head was bent over and R1 still had a weak pulse and was breathing slowly. V25 asked the following CNAs to take R1 to his room and put him to bed. V26 and V27 took R1 to his room and put him in bed with the code board behind his bag. I (V25) had called EMS while they (CNAs) were putting R1 into the bed. After R1 was in bed V26 went to get the code cart and equipment. Upon returning with the code cart compressions were being done by V27 and I (V25) hooked up the AED to R1's chest. The AED would not work I don't know if the battery was dead or what the problem was. We started doing chest compressions and V26 was using the Ambu bag. EMS arrived and they took over the situation with R1. R1 was pronounced dead by EMS after performing compression with R1 for 20 minutes. EMS called the coroner and R1's body was taken to the local hospital morgue due to not listing a funeral home on his admission papers.On [DATE] at 2:04 PM, V2 Director of Nursing stated No I do not believe the AED would have changed the outcome for R1. The girls started doing the CPR procedure immediately. We do not have the AED here anymore and the last time it was checked was last of June. The AED was not checked on [DATE]st to [DATE]th and on [DATE] we found out it was not working. The AED should be checked daily. We have a form we use to check off the equipment was checked. Facility policy titled Automated External Defibrillator, Use and Care Of. This policy is undated. The section titled Maintaining the AED: states 1. Check the device and perform maintenance tasks, as directed in the AED Manual.