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	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charleston Rehab and Nursing	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's family, physician and Hospice after a change in residents' condition, post traumatic fall. This failure affected one of three residents (R1) reviewed for falls/change in conditon, on a sample list of 18.Findings include:R1's most recent diagnoses list includes the following: carcinoma of the left bronchus in situ, senile degeneration of the brain, chronic respiratory failure with hypoxia, hypertensive heart disease with heart failure, chronic kidney disease stage IV, unspecified muscle disorder, unsteadiness on feet, and lack of coordination.R1's most recent Physician Order Sheet documents: Admit to (private company) Hospice services related to adenocarcinoma of the left lung and bronchus. Prognosis: six months or less with normal disease progression. Start date: 7/15/25.R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview for Mental Status score was 5 out of 15, indicating severe cognitive impairment.R1's Fall Incident Report dated 12/06/25 at 7:30 p.m. documents V11, Licensed Practical Nurse (LPN), was R1's nurse and states, No notifications found.On 2/6/26 at 1:30 p.m., R1's family members, V7 and V8, stated neither of them had been notified of R1's fall on 12/06/25 until 12/07/25.On 2/06/26 at 2:45 p.m., V6, R1's Power of Attorney, stated she was not notified of R1's 12/06/25 fall until 12/07/25.On 2/6/26 at 3:20 p.m., V10, Licensed Practical Nurse (LPN), stated that when she arrived at work on 12/07/25, V11 reported during shift report that R1 had fallen the evening of 12/06/25 at 7:30 p.m. V11 also stated there was no documentation that she had notified a physician, hospice, or family member regarding R1's fall. V10 stated she attempted to reach family and hospice, and both arrived at the facility promptly. V10 also stated R1 was lethargic, unable to speak, and moaning during her 12/07/25 assessment.On 2/09/26 at 10:30 a.m., V5, Hospice Registered Nurse (RN), confirmed hospice was not notified of R1's fall that occurred on 12/06/25 at 7:30 p.m. until V10, LPN (day shift), notified hospice on 12/07/25 at approximately 8:00 a.m. V5 stated she then contacted R1's Power of Attorney (V6). V5 further stated, From my experience as a hospice nurse, (R1) had a concussion and likely a brain bleed. She was comatose post-fall and had changes in her swallowing and breathing. She showed no emotion. Had the facility called the night of the sixth (12/06/25), hospice staff would have been bedside to provide comfort and emotional support, as we did once we were notified.On 2/10/26 at 9:25 a.m., V2, Director of Nursing (DON), stated, R1's family should have been called immediately, as well as the provider and hospice. That is standard practice.On 2/13/26 at 2:25 p.m., V11, Licensed Practical Nurse (LPN), confirmed she was R1's nurse on 12/06/25 when R1 fell. V11 stated it was a hectic night, and she had not notified R1's family, physician, or hospice.The facility's Policy and Procedure: Fall Reduction Policy, revised 10/30/25, documents:4.) a. ii. Evaluate and assess the resident for injury. Guidelines will be utilized as appropriate to each situation and change in condition. Notify the physician Notify the responsible party Contact the on-call nurseThe (private company) Hospice Contract guidelines state: Services provided to the (continued on next page)

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
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient relating to the management of the terminal illness (CT scans, X-rays, lab work, additional procedures) may be provided to the hospice patient only with the express preauthorization of (private company) Hospice. Facility staff are to contact our Administrator on Call (AOC) for authorization. The AOC is available 24 hours a day, 7 days a week.

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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 interviews and record review, the facility failed to ensure R17 was free from witnessed resident to resident emotional and verbal abuse. R17 is one of four residents reviewed for abuse on the sample list of 18.Findings include:R16's Current Physician Order Sheet (POS) documents the following diagnoses and medication: Risperidone Oral Tablet 1 MG (milligram), Give 1 tablet by mouth at bedtime to take with 0.5 mg to equal 1.5 mg. Related to Undifferentiated Schizophrenia and Bipolar Disorder, Unspecified.R16's Minimum Data Set (MDS) dated [DATE] documents R16's Brief Interview of Mental Status (BIMS) score as 15 out of 15, indicating no cognitive impairment.R17's Current POS documents the following diagnoses and medications: Sertraline HCl Oral Tablet 50 MG, Give 1 tablet by mouth one time a day, Depression Unspecified, and Aripiprazole Oral Tablet 5 MG, Give 3 tablets by mouth one time a day for Antipsychotic - Unspecified Psychosis Not Due to a Substance Or Known Physiological Condition.R17's MDS dated [DATE] documents R17's BIMS score as 14 out of a possible 15, indicating no cognitive impairment.The facility-reported incident, final State Report dated 01/16/26 documents that on 01/10/26 at 4:40 pm an allegation of verbal abuse was identified as follows: Resident (R16) to resident (R17) verbal exchange.The same facility-reported incident, with witness statements, documents: Disposition:Skin and pain assessments were completed on both residents. 72-hour monitoring for s/s (signs and symptoms) of psychosocial distress was completed for both residents. All staff are educated on Resident Right to Be Free from Abuse, Neglect and Exploitation Policy.The same facility-reported incident documents the following typed (not handwritten) witness statements that omit some information this surveyor received in interviews and documented below. The facility-reported incident documents:Statement from (V35), Cook: Incident in the Dining Room. (V33, Dietary Assistant) and (R17) were joking with each other. (V16) became upset and yelled, shut the (F-expletive) up. I (V35) intervened. I informed (R17) that we cannot act like that in the dining room. I told him we all have to be nice. (R16) and (R18, R16's fiance) then decided to eat in their rooms.The same facility-reported incident documents:Statement from (V34, Dietary Assistant): I was doing my sub-list and I heard (R16) saying shut the (F-expletive) up when (R17) was laughing, and (R16) made (R17) upset, so he (R17) went back to his room and it (sic) calmed down and (sic) they wanted to eat in (R18's) room and (sic) they talked to the nurse, and I have no clue what happened after that because I was back to working and doing my sub-list.The same facility-reported incident documents:Statement from (V33, Dietary Assistant): At about 4:30 pm, (R17) came up for tea and (V35, Cook) said, 'Hey (R17), (V33) stinks,' then (R17) started laughing and we started to joke around with him. Then out of nowhere (R16) yelled, 'Shut the (F-expletive) up.' Originally I assumed this was directed at (R17), so I told him this is everyone's home, not just his. Then after that (V35) and other staff (unidentified) tried to de-escalate the situation.The same facility-reported incident documents:Statement from (R16): I did yell (sic) 'shut the (F-expletive) up.' I yelled because people were being loud and I had a headache. I didn't yell at anyone specifically, and it wasn't toward (R17) because he is my friend.The same facility-reported incident documents:Statement from (R17): I heard (R16) yell something. I don't know what it was. He was upset. He is my friend.The same facility-reported incident documents:(R16) is care planned for: (R16) has noted behavior of being aggressive with other residents. Known to yell or argue inappropriately with others. When others attempt to move (sic) from his behaviors, (R16) will, on occasion, follow them, continuing to be rude/inappropriate.Interventions in place: Staff will intervene when (R16) is having behaviors toward other residents. Staff will ensure that everyone is safe; staff will meet (R16's) nursing needs as needed, keeping (R16) safe; staff will (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitor all inappropriate behaviors: type of behavior, time of day, what may have provoked behavior, staff present, how it was resolved, and whether it was effective.Both residents have been showing no s/s of psychosocial distress.On 2/06/26 at 10:20 am, R7 stated the following: I was in the activity room by the dining room. I overheard (R16 and R17) one day in the dining room. (R16) yelled some pretty bad words in there at (R17). (R17) left crying. I can't repeat the words and can't pinpoint the day.On 2/06/26 at 11:00 am, R14 stated, There was a guy (R16) at my (R14) table (R14, R16, and R18 dine together). (R16) was cussing up a blue streak at another resident (R17) who was in the dining room to eat. It was not directed at me, but I thought the whole thing was uncalled for. That was a couple weeks ago, as I remember it.On 2/10/26 at 9:25 am, V1, Administrator/Abuse Prevention, stated she had not had time to scan the investigation of the allegation that R16 verbally abused R17 in the dining room on 1/10/26. V1 stated, It happened, and I know you are waiting on the report.On 2/6/26 at 3:05 pm, R17 stated, It seems like I have talked to a lot of people about (R16) yelling at me in the dining room. I (R17) cried and went back to my room when he would not stop cussing at me. I thought he (R16) and I (R17) were friends. Friends don't use the F-word or tell you to shut up. I am not sure what his problem was that day. I was just hanging out in the dining room with the cooks while I waited on them to serve the food. I was overwhelmed at the time. I have depression. Yelling profanities at me does not help. I am tearing up (observed as he talked) now just talking about the ordeal.On 2/11/26 at 1:55 pm, V33, Dietary Assistant, stated, Yes, I witnessed (R16) verbally abuse (R17). It was awful. (R16) was in the dining room and started yelling (F-expletive) repeatedly. The dining room was half full. He was looking at (R17), who was engaged in conversation with one of the dietary staff. (R17) was laughing, and I think (R16) thought he was laughing at him. (R17) tried to go ahead and eat at his table. (R16) was sitting at his table eating. I told (R16) it was not okay for him to talk like that in the dining room around other people. I felt so bad for (R17). He (R17) started crying and ended up leaving the dining room about 5 minutes later.On 2/11/26 at 2:00 pm, V35, Cook, confirmed R16 yelled, Shut the (F-expletive) up, at R17, who left the dining room upset and crying.On 2/13/26 at 12:30 pm, R16 stated, Hell yes, I put (R17) in his place. I yelled some harsh words because (R17) was talking to somebody in the kitchen and he was laughing. I thought he was laughing at me. I was with my girlfriend (R18), and we were in the dining room trying to eat. They were cutting up. (R17) came to me later crying and asked me if I was still his friend. I said yes, we've been friends for a long time. I just said yes because I wanted him to stop crying. (R18) and I finished eating our meals in the dining room and went back down the hall to her room to visit. (R17) had been gone for probably 15 minutes before we left the dining room. I don't know if he came back down to finish eating or not.The facility policy Resident Right to Freedom from Abuse, Neglect and Exploitation dated 01/16/2023 documents the following:Policy StatementThe Facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in this policy. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (Associates).Policy Interpretation and ImplementationI. Associates must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion against any resident.II. The Facility will ensure that residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	least amount of time and document ongoing re-evaluation of the need for restraints.III. The Facility shall review altercations from resident to resident as a potential situation of abuse.A. Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to:a. Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;b. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;c. Sexually aggressive behavior, such as saying sexual things, inappropriate touching/grabbing;d. Taking, touching, or rummaging through others' property; ande. Wandering into others' rooms/spaces.The same policy documents:IV. When the Facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to:a. Taking steps to prevent further potential abuse;b. Reporting the alleged violation and investigation within required timeframes pursuant to federal and state statutes and regulations (see Elder Justice Act policy);c. Conducting a thorough investigation of the alleged violation; andd. Taking appropriate corrective action.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to complete a thorough investigation, by failing to interview other residents/staff (R16) resident (R17), and R3 and R4 alleged verbal abuse and failed to remove the alleged perpetrator (R16) from a resident shared dining room post witnessed verbal abuse. These failures affected three of four residents, (R3, R4, and R17) reviewed for abuse, and two additional resident (R7 and R14) on the sample list of 18.Findings include:The facility-reported incident, final State Report, dated 01/16/26 documents that on 01/10/26 at 4:40 PM an allegation of verbal abuse was identified as follows: Resident (R16) to resident (R17) verbal exchange.The same facility-reported incident includes staff witness statements; however, it does not include interviews from other residents who may have been present at that end of the dining room.On 02/06/26 at 10:20 AM, R7 stated I was in the activity room by the dining room. I overheard (R16 and R17) one day in the dining room. (R16) yelled some pretty bad words at (R17). (R17) left crying. I can't repeat the words and can't pinpoint the day.On 02/06/26 at 11:00 AM, R14 stated There was a guy (R16) at my table (R14, R16, and R18 dine together). (R16) was cussing up a blue streak at another resident (R17) who was in the dining room to eat. It was not directed at me, but I thought the whole thing was uncalled for. That was a couple weeks ago, as I remember it.On 02/13/26 at 12:30 PM, R16 stated Hell yes, I put (R17) in his place. I yelled some harsh words because (R17) was talking to somebody in the kitchen and laughing. I thought he was laughing at me. I was with my girlfriend (R18), and we were in the dining room trying to eat. They were cutting up. (R17) came to me later crying and asked me if I was still his friend. I said yes we've been friends a long time. I just said yes because I wanted him to stop crying. (R18) and I finished eating our meals in the dining room and went down the hall to her room to visit. (R17) had been gone for probably 15 minutes before we left. I don't know if he came back to finish eating or not.On 02/13/26 at 12:40 PM, R18 stated: I was present when my fiance (R16) yelled at (R17). My fiance can get headstrong. He was really agitated because (R17) was laughing. He thought it was at him. He yelled some curse words. Staff talked to him about it already. Everything was okay after (R17) left the dining room and went into the activity room. I could see that (R17) was upset and crying as he left. We finished our lunch. About 15 or 20 minutes later we left the dining room and went down to my room to visit.R18 further stated the shared dining room had several other residents present who were spread throughout the room eating, but she was not sure of their names or who heard what.On 02/11/26 at 1:55 PM, V33, Dietary Assistant, stated she witnessed R16 verbally abuse R17 while other unidentified residents were present in the dining room.A second facility-reported incident, final State Report, dated 12/12/25 documents that on 12/08/25 at 11:20 AM an allegation of verbal abuse was identified as follows: Resident (R3) to resident (R4) verbal exchange.The same report documents the following disposition:Investigation initiated; final report to follow.Skin, pain, and trauma-informed care assessments were completed on both residents.Staff were educated on the Abuse, Prevention & Prohibition Policy.Statement from V50, Certified Nursing Assistant: While sitting at the nursing desk charting, (R3) was cursing out (R4). (R3) told him she hoped he chokes on his water and dies. (R4) asked if he heard her right. (R3) repeated it again and said, 'Yeah, I said it.' I told her that was not okay and removed her from the hall. I reported the incident to (V51), Assistant Director of Nursing, and (V1), Administrator/Abuse Prevention Coordinator.The report documents that R3 does not recall the incident.Statement from R4 I don't recall word for word what she said. I do know she wasn't very nice and cussed at me. I think she thought I was in her way or something.The same facility-reported incident does not include additional resident or staff interviews.On 02/11/26 at 3:05 PM, V1, Administrator/Abuse Prevention Coordinator, reviewed hard copies of the abuse allegation investigations and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she observed that the investigations for R3/R4 and R16/R17 did not include witness statements from other residents, which is part of a thorough investigation. V1 also stated she thought R16 went directly to his room after the altercation. She further stated I was not in the building at the time. I had to go by what I heard when it was reported to me. I guess I just misunderstood. (R16) should not have been in the dining room at all after shouting profanities at (R17).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed repeatedly to provide the receiving supportive living facility complete and accurate personal identity, residents fund, Medicare and Social Security documents, and proof of purchase for a mobility device to ensure a resident continuity of care, and discharge occurred in a timely manner. This failure affected one of four residents (R2) reviewed for resident rights/discharge on the sample list of 18.Findings include:R2's most recent Diagnoses list documents the following:Diagnoses: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Foot Drop, Right Foot, Cerebral Infarction Unspecified, Aphasia Following Cerebral Infarction, Expressive Language Disorder, Major Depressive Disorder, Recurrent Pain Unspecified, and Unsteadiness on Feet.R2's Minimum Data Set (MDS) dated [DATE] documents R2 has no memory issues is marked (a Brief Interview of Mental Status assessment was not completed) The same MDS documents R2 and uses a manual wheelchair for mobility.R2's most recent Physician Order Sheet (POS) documents: Ok to d/c (discharge) to assisted living facility, will need wheelchair and cushion. No directions specified for order. Other 11/4/2025 (one month and 13 days before R2's discharge 12/17/25).R2's same POS documents the following: Discharge resident to assisted living facility. Resident requires a wheelchair for mobility due to Cerebral Infarction, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Right Dominant Side. Wheelchair size is 18 inches, x16 inches, x17 inches in height. Wheelchair cushions can be no thicker than 2 (two) inches. Bilateral swing away footrest. Order dated 11/7/2025 (one month and ten days before discharge). There is no documentation in R2's medical record to confirm a new wheelchair had or had not been ordered.R2's Discharge (D/C) Summary dated 12/17/2025 at 2:20 pm documents the following: Note Text: D/C education performed (sic) to res (resident R2), staff from (Local- Private Name, Supportive Care Facility) present and ready to transport res, res signed appropriate paperwork per facility protocol, meds (medication) sent w/res (with resident), res took w/c (wheelchair) (several years old, according to R2's interview below) and hemi-walker (specialized, assistive device for impaired cerebrovascular accident/CVA patients) on d/c as they belong to res, no further concerns at this time.On 1/22/26 at 2:10 pm this surveyor went to the local supportive living facility that R2 currently resides in. (R2) was in her apartment and answered her door in a wheelchair. The left arm of R2's wheelchair was visibly in disrepair. The plastic wall of the seat, holding the arm rest, was cracked in several pieces. There was an approximately two-inch section of the broken plastic wall that was bent inward. The end of the bent plastic was wrapped in a thin, elastic bandage tape and abutted R2's left hip. The same arm rest had an approximate five-inch chunk of plastic missing. The right arm rest was wrapped in a disposable thin, elastic bandage tape like wrap. R2's right arm was flaccid and laid across R2's lap. R2 stated I was not neglected, the issues I had with (Skilled Care Facility) was that they neglected to provide my paperwork, which delayed my discharge from (Skilled Care Facility) to (Supportive Care Facility) for months. They could not provide (Supportive Care Facility) with the paperwork needed for me to transfer. I waited months on end and asked (V1) the Administrator all the time. They also never got me my new wheelchair. R2 stated I asked, and I begged for a new wheelchair for months. Then in August, that is when I became eligible for Medicare, getting the facility (Skilled Care Facility) to submit my paperwork for the new wheelchair. It was supposedly in the works when I had Meridan Medicaid insurance. I continued to beg right up until I came here (Supportive Living Facility), (12/17/25). They ignored me. I talked to the (V1), Administrator, and she would say she would check into it. She never did. R2 then tugs at a very worn cushion in the wheelchair seat. You see, you see, this is (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bad, the cushion hurts my butt. The broken plastic here at the side of the wheelchair pokes me and hurts my hip. I have to be extra careful all the time, or I get jabbed. R2 then asked this surveyor to talk to (V21), Executive Director of (Supportive Living Facility). He will tell you how I waited and waited to get in here. He knows all about my chair problem too. (Skilled Care Facility) said at one time they were purchasing one and later said they did not. I hope you can sort this out. I am very uncomfortable in the one I am using. It is old and I have had it for years, since my stroke. R2 also stated (V22, Medicaid) my social worker has been involved with getting my wheelchair since October of 2023, I believe. She has been talking to (Skilled Care Facility), and no one seems to have the information. I had to come here with this broken-up wheelchair with the cracked-up, side panel. The cushion is worn tattered and flat. If you could talk to (V21) and (V22) they can give you all the updates. My chair has been the issue since early summer with Medicare (issues prior as documented below when on Medicaid), when they said they were ordering it again. I qualified to get one. I am still waiting. Just like I was put off for months to come to (Supportive Living) because (Skilled Care Facility) is not doing what they are supposed to do. I don't know how many times (V21) asked for the papers needed to come here. I believe it was back in January or February 2025. I asked a head (before) of August, when I was eligible (Medicare) and continued to ask the (V1) Administrator. She really ignored me.On 1/22/26 at 3:00 pm V21, Executive Director of (Supportive Living) stated We have experienced numerous delays by (Skilled Care Facility) in getting (R2's) documents in order for her to be admitted here in Supportive Living. (R2) turned 65, on 8/2/25. For months prior to that (8/2/25), we were attempting to get information from (Skilled Care Facility). They had no active Social Security card or the award letter for her. They couldn't figure out if she was Medicaid or private pay. Then when we asked for the balance of her funds that she had. The facility had no idea. (Skilled Care Facility) finally sent us a ledger with every resident on it. They blacked out the other residents' names on the ledger they were trying to send. Funds looked like they were all commingled with other residents' funds. They did not have separate documentation statement for their resident funds. It took months to put it all together. It was due to (Skilled Care Facility) not having the documents together to complete (R2's) admission packet that we had given them. We were very concerned. We weren't sure if (R2) had Medicare, Medicaid, Private Pay or what. V21 also stated She (R2) has mentioned the wheelchair since she got here (12/17/25), and before. Medicare will only cover one wheelchair every five years. The facility initially told us that they had initiated the purchase. We repeatedly asked prior to and before her admission on [DATE]. She could have been admitted on [DATE] had the facility provided the documents we requested. There were no care issues that we identified nor that (R2) had pointed out to us, other than the accommodating her need for a new wheelchair. It would be great to figure out if they have ordered it or if they have not, we are still trying to get the information from (Skilled Care Facility). We need to identify the next course of action. As you can see, (R2's) wheelchair is not appropriate. It is in serious disrepair. I have gone on (web-based store) and considered purchasing one for her. She admitted here last month. (Skilled Care Facility) has delayed information consistently, that they said would be provided. In the meantime, we have adjusted a cushion in the chair just to make the wheelchair she has somewhat more comfortable. It is not adequate. She has had a stroke and needs to be provided with the supportive cushion to adapts to her lean. As you can see, she has some kind of tape on the armrest. The plastic panel under the armrest is cracked and in part broken in pieces. (Skilled Care Facility) could not locate anything for her to use for the transition, while she is waiting on the new chair. She really wanted to be here, and she really qualified to be here. Had her documents been in order there (Skilled Care Facility), we could (continued on next page)

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	145636	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have made a smooth transition. The admission paperwork, Medicare and social security documents number, funds, and the wheelchair have been the issue.On 1/22/26 at 3:20 PM. V24, Director of Marketing/Sales Supportive Care facility and V23, Business Office Manager confirmed the Skilled care facility failed to provide R2's paperwork and purchase R2's wheelchair caused the delay in R2's admission to the Supportive Care facility since R2's eligibility 08/02/25.On 2/10/26 at 4:45 pm V1, Administrator confirmed R2's delay in discharge to the supportive living facility was due to paperwork, identification records and resident funds records had not been submitted to the supportive living facility by previous V28, Previous Skilled Care, Business Office Manager. V1, Administrator also confirmed the facility did not purchase R2's wheelchair and confirmed R2 requested repeatedly for the past year and had to discharge to the supportive living facility with R2's broken wheelchair.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to obtain and arrange for a wheelchair replacement for a dependent resident. This failure resulted in R2's prolonged use of a wheelchair in disrepair. R2 is one of three residents reviewed for quality care and service on the sample list of 18.Findings include:R2's most recent Diagnoses List documents the following diagnoses: Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominant side; foot drop, right foot; Cerebral Infarction, unspecified; Aphasia following Cerebral Infarction; expressive language disorder; Major Depressive Disorder; recurrent pain, unspecified; and unsteadiness on feet.R2's Minimum Data Set (MDS), dated [DATE], documents R2 has no memory issues and is marked as not having had a Brief Interview of Mental Status assessment completed. The MDS also documents R2 uses a manual wheelchair for mobility.R2's Medication Administration Record (MAR), dated December 2025, documents R2 required the following pain medication to maintain comfort: Tylenol 8-Hour Arthritis (an arthritic analgesic similar to regular Tylenol but with extended pain relief), oral tablet extended-release 650 mg, give one tablet by mouth one time a day for pain, scheduled at 5:00 a.m., and give one tablet by mouth one time a day. R2's MAR documents R2 was administered the pain medication as ordered by the physician until R2's 12/17/25 discharge.R2's most recent Physician Order Sheet (POS) documents: Ok to d/c (discharge) to assisted living facility; will need wheelchair and cushion. No directions specified for order. Other 11/4/2025 (one month and 13 days before R2's discharge on [DATE]).R2's same POS documents the following: Discharge resident to assisted living facility. Resident requires a wheelchair for mobility due to cerebral infarction; hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right dominant side. Wheelchair size is 18 inches x 16 inches x 17 inches in height. Wheelchair cushions can be no thicker than two inches. Bilateral swing-away footrests. Order dated 11/7/2025 (one month and ten days before discharge).R2's Discharge summary dated [DATE] at 2:20 p.m. documents the following: Note Text: D/C education performed (sic) to res (resident R2); staff from (Local Private Name Supportive Care Facility) present and ready to transport res; res signed appropriate paperwork per facility protocol; meds sent w/res; res took w/c (wheelchair) (several years old, according to R2's interview below) and hemi-walker (specialized assistive device for impaired CVA patients) on d/c, as they belong to res; no further concerns at this time.On 1/22/26 at 2:10 p.m., this surveyor went to the local supportive living facility where R2 currently resides. R2 was in her apartment and answered her door in a wheelchair. The left arm of R2's wheelchair was visibly in disrepair. The plastic wall of the seat holding the armrest was cracked into several pieces. There was an approximately two-inch section of broken plastic bent inward. The end of the bent plastic was wrapped in thin elastic bandage tape and abutted R2's left hip. The same armrest had an approximately five-inch section of plastic missing. The right armrest was wrapped in a disposable, thin elastic bandage-type wrap. R2's right arm was flaccid and rested across her lap.R2 stated, I was not neglected. The issues I had with (Skilled Care Facility) were that they neglected to provide my paperwork, which delayed my discharge from (Skilled Care Facility) to (Supportive Care Facility) for months. They could not provide (Supportive Care Facility) with the paperwork needed for me to transfer. I waited months on end and asked (V1), the Administrator, all the time. They also never got me my new wheelchair.R2 stated, I asked and begged for a new wheelchair for months. Then, in August, that is when I became eligible for Medicare. Getting the facility to submit my paperwork for the new wheelchair was supposedly in the works when I had Meridian Medicaid insurance. I continued to beg right up until I came here (Supportive Living Facility) on 12/17/25. They ignored me. I talked to (V1), the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator, and she would say she would check into it. She never did.R2 then tugged at a very worn cushion in the wheelchair seat and stated, You see, you see, this is bad. The cushion hurts my butt. The broken plastic here at the side of the wheelchair pokes me and hurts my hip. I have to be extra careful all the time, or I get jabbed. R2 then asked this surveyor to speak to (V21), Executive Director of (Supportive Living Facility), stating, He will tell you how I waited and waited to get in here. He knows all about my chair problem too. (Skilled Care Facility) said at one time they were purchasing one and later said they did not. I hope you can sort this out. I am very uncomfortable in the one I am using. It is old and I have had it for years, since my stroke.R2 also stated, (V22), my social worker from Meridian Medicaid, has been involved with getting my wheelchair since October of 2023, I believe. She has been talking to (Skilled Care Facility), and no one seems to have the information. I had to come here with this broken wheelchair with the cracked side panel. The cushion is worn, tattered, and flat. If you could talk to (V21) and (V22), they can give you all the updates. My chair has been the issue since early summer with Medicare (issues prior as documented below when on Medicaid), when they said they were ordering it again. I qualified to get one. I am still waiting. Just like I was put off for months to come to (Supportive Living) because (Skilled Care Facility) is not doing what they are supposed to do. I don't know how many times (V21) asked for the papers needed to come here. I believe it was back in January or February 2025. I asked ahead of August, when I was eligible for Medicare, and continued to ask (V1), the Administrator. She really ignored me.On 2/10/26 at 12:50 p.m., V22, Community/Social Worker for Meridian Medicaid, stated that although R2 is no longer under Meridian Health Care, V22 had been R2's case manager for years while R2 resided in the skilled care facility. V22 stated, I had been trying to get R2 a new wheelchair since 9/12/22 (three years and five months ago). I had asked (Skilled Care Facility) repeatedly for paperwork needed. They gave me the runaround. Finally, I talked to one of the nurse practitioners (unidentified), who gave the order for a new wheelchair. R2's wheelchair was in bad shape. The wheelchair was cutting into her side. R2 even tried taping the plastic side together. I was hoping the wheelchair would be provided by the time she went to (Supportive Living). I came into (Skilled Care Facility) multiple times asking about her wheelchair. The last time I was there, I was told since R2 was now on Medicare as of her birthday (8/2/25), I had no role in her case. Meridian was not her insurance any longer.V22 also stated, I really tried to work with the nursing home (Skilled Care Facility). At first, they kept saying they lost the paperwork due to the old ownership of the facility. Then they repeatedly said the same thing once new ownership was in place. They couldn't provide the papers needed. Medicaid would have provided the new wheelchair had they done their part.On 2/10/26 at 4:45 p.m., V1, Administrator, confirmed R2's delay in discharge to the supportive living facility was due to paperwork, identification records, and resident funds records not being submitted to the supportive living facility by the previous facility's V28, Business Office Manager. V1 also confirmed the facility did not purchase R2's wheelchair and confirmed R2 had requested one repeatedly over the past year.

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F 0689 Level of Harm - 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 record review, and interview, the facility failed to identify appropriate targeted intervention post previous fall, for a resident (R1) with severe cognitive impairment, failed to maintain a mobility device within R1's reach to prevent an unwitnessed fall, failed to initiate neurological and physical assessments post the unwitnessed fall. These failures affected one of three residents (R1) reviewed for falls on the sample list of 18. These failures resulted in a severe head injury and untreated pain.Findings include:R1's most recent Diagnoses List included the following: Carcinoma of the left Bronchus in Situ; Senile Degeneration of the Brain; Chronic Respiratory failure with Hypoxia; Hypertensive Heart Disease with Heart Failure; Chronic Kidney Disease stage IV; disorder of muscle, unspecified; unsteadiness on feet; and other lack of coordination.R1's Minimum Data Set (MDS), dated [DATE] (prior to R1's three unwitnessed falls on 10/7/25, 10/28/25, and 12/06/25 described below), documents R1's Brief Interview of Mental Status score as five out of 15, indicating severe cognitive impairment. The same MDS documents R1 had no falls during the assessment look-back period, required supervision and contact assistance with toileting, and required a wheelchair for mobility.R1's Fall Investigation Report dated 10/7/25 at 10:30 p.m. documents R1 had an unwitnessed fall while getting up to go to the bathroom and fell over the recliner chair footrest. The same report documents that R1 hit her face on the floor and that V5, R1's Power of Attorney (POA), wanted R1 sent to the hospital.R1's corresponding Health Status Note dated 10/08/25 at 12:58 a.m. documents R1 returned with a small laceration to her head, no dressing, and no new orders.The facility's Fall Log/Analysis documents R1's fall intervention for 10/08/25 as: Make sure R1's call light was within reach and functioning. (R1 has severe cognitive impairment; V2, Director of Nursing, confirmed below this was not an appropriate intervention.) This intervention had already been in place since 03/10/25. There was no new targeted intervention to address toileting or the footrest documented after the fall of 10/7/25.R1's Fall Investigation Report dated 10/28/25 at 2:05 a.m. documents R1 had an unwitnessed fall and could not say what happened. The same report documents R1 was found on the floor. The intervention documented was to educate R1 to activate her call light when she needed help and wait for assistance (R1 has severe cognitive impairment, and V2 confirmed this was not an appropriate intervention).R1's Fall Incident Report dated 12/06/25 at 7:30 p.m. documents V11, Licensed Practical Nurse (LPN), as the person preparing the report.The same report documents:Nurse's Description: Resident was moving from one bed to the other in her room and fell on the floor. Resident has a small bump to her head by the right eye on forehead. Resident states she has no pain; head does not hurt. Vitals were taken.Resident Description: Resident stated she was trying to get to the other bed when she slipped and fell.Immediate Action Taken: Vital signs taken (completed by V31, Certified Nursing Assistant (CNA), according to interview below), resident assessed and helped back to bed, and instructed to use call light for help (R1 has severe cognitive impairment as noted above).V31's interview, documented below, stated V31 was the staff member who found R1 on the floor and that R1's wheelchair was across the room, out of R1's reach, when she was found.R1's Care Plan documents a fall intervention dated 3/10/25 stating assistive devices will be within reach of the resident.R1's Neurological Assessment Flow Sheet initiated 12/06/25 documents the following required checks:Every 15 minutes for one hourEvery hour for four hoursEvery four hours for 19 hoursThe same Neurological Assessment Flow Sheet documents the following for 12/06/25 at 7:30 p.m.:Level of Consciousness: S (stuporous, near unconsciousness)Pupil response: blank (not measured)Hand grips: blank (not measured)Motor function extremities: U (unable to follow directions)Pain: blank (not measured)Vital signs (blood pressure, temperature, pulse, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	respiration): blank (not measured)Observations: blankSignature: blank (nurse not identified)The same form documents that all assessment boxes were blank at the following times:7:45 p.m.8:00 p.m.8:15 p.m.9:15 p.m.10:15 p.m.11:15 p.m.3:15 a.m. on 12/07/25R1's Medication Administration Record (MAR) dated December 2025 documents the following medications were not administered to R1 on 12/06/25: Lorazepam Oral Concentrate 2 mg/mL, give 0.25 mL by mouth every four hours as needed for anxiety, agitation, or restlessness (hospice admission order), and Morphine Sulfate Concentrate Oral Solution 20 mg/mL, give 0.25 mL by mouth every two hours as needed for pain and dyspnea (hospice admission order).On 2/6/26 at 1:30 p.m., R1's family members/complainants V7 and V8 stated they had not been notified of R1's fall. V7 stated, We would have come in right away. It happened early evening (12/06/25). V7 and V8 also stated they had been told by an unidentified CNA that The nurse (V11, LPN) told two CNAs (V31 and V32) to get R1 up off the floor and put her back in bed without the nurse completing an assessment. The nurse told the CNAs she would give R1 morphine. I hope she did. When I saw her, she was moaning, and her face was swollen and bruised. She had to be in a great deal of pain.On 2/6/26 at 3:20 p.m., V10, LPN, stated that when she came to work on 12/07/25, V11 told her in report that R1 had fallen the evening of 12/06/25 at 7:30 p.m. V10 also stated there was no documentation that V11 had completed neurological assessments or contacted a physician, hospice, or family about R1's fall. V10 stated she tried to reach family and hospice, and both came into the facility right away. V10 also stated R1 was lethargic, could not talk, but moaned during her assessment.On 2/09/26 at 10:30 a.m., V5, Hospice Registered Nurse (RN), confirmed hospice was not notified of the 12/06/25 7:30 p.m. fall until 12/07/25 at approximately 8:00 a.m. V5 stated, It's protocol for hospice to be notified immediately of falls. We come out and do our own assessment. R1 was in decline prior, but she was still alert and could have conversations the day before. She was totally different when I came in on 12/7/25 to see her. She had obviously taken a serious fall and needed to be evaluated sooner. She could not hold a conversation. She was lethargic. V5 also stated, From my experience as a hospice nurse, R1 had a concussion and likely a brain bleed. She was comatose post-fall, had a change in swallowing and breathing, and showed no emotion. Had the facility called the night of 12/06/25, hospice staff would have been bedside to provide comfort and emotional support, as we did once we were notified.On 2/11/26 at 3:25 p.m., V2, Director of Nursing (not employed at the facility when R1 fell but experienced in investigating falls), reviewed investigations for R1's falls on 10/7/25, 10/28/25, and 12/06/25, along with care plans, assessments, neurological assessments, vital-sign documentation, interventions, and fall reports. V2 stated it is standard practice to thoroughly assess a resident post-fall. V2 confirmed the following: neurological assessments were not completed after the 12/06/25 fall; no appropriate notifications were made to family, physician, or hospice; no thorough investigation was conducted to determine root cause; reminding R1 to use the call light was not appropriate due to R1's cognitive impairment; and toileting should have been addressed after the 10/07/25 fall since R1 had been attempting to go to the bathroom independently.On 2/13/26 at 11:35 a.m., V31, CNA, stated she was R1's CNA the night R1 fell. V31 stated she heard R1 say, Help me, looked into R1's room, and saw her lying on the floor between her bed and the bathroom. V31 stated R1 could not speak words and was mumbling and groaning. V31 reported R1 appeared to be in pain and notified V11 immediately. V31 stated that when V11 came in, she did not assess R1 and told staff to get her up. V31 stated R1 had a large bump above her right eyebrow that swelled immediately and that R1 did not have her oxygen on. V31 stated they attempted to stand R1, but her legs gave out, and they dragged her to the bed. V31 stated V11 left the room immediately afterward. V32 then obtained vital signs. V31 stated R1 continued moaning and appeared in pain. V31 reported V11 later said she would give morphine but (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	instead sat at the desk on her phone and reading.On 2/13/26 at 2:25 p.m., V11, LPN, stated it was a really hectic night when R1 fell and acknowledged she did not complete a full physical or neurological assessment. V11 confirmed R1 was moaning in pain at times throughout the night. Although R1's MAR does not document administration of morphine after the fall, V11 stated she was not sure whether she had given it.The facility's Policy and Procedure Fall Reduction Policy, revised 10/30/25, documents:4.a.ii. Evaluate/assess the resident for injury. Guidelines will be utilized as appropriate to each situation and change in condition.Notify the physicianNotify the responsible partyContact on-call nurseThe facility's Policy and Procedure Neurological Assessment, dated 11/05/25, states the purpose is to evaluate condition and provide professional nursing assessment and intervention for possible head injuries. General assessment guidelines include, but are not limited to: new onset changes in cognitive status; speech or communication changes; sensory changes; swallowing changes; balance and gait changes; headaches, dizziness, pupillary constriction, weakness, tremors, nausea, or vomiting; drowsiness or irritability; fluid or bleeding from ears; and changes in respiratory pattern.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility repeatedly failed to ensure transportation and nursing preparation for dental appointments which resulted in a delay in dental extractions. These failures affected one of four residents (R7) reviewed for resident rights/quality of care on the sample list of 18.Findings include: R7's Minimum Data Set (MDS) dated [DATE] documents that R7 has a Brief Interview of Mental Status score of 15 out of 15, indicating no cognitive impairment.R7's Care Plan dated 11/30/25 documents the following:Dental Care: R7 has poor dentition with obvious tooth decay and some broken teeth. He consumes regular-textured food without difficulty.Will be free from mouth pain for 90 days. Date initiated: 03/10/2023.Observe for complaints of mouth pain (e.g., difficulty chewing, refusal to eat or drink, grimacing, touching or rubbing affected area of face). Date initiated: 03/10/2023.Observe for unexplained weight loss that could be caused by mouth pain. Date initiated: 03/10/2023.Obtain dental consult PRN (as needed). Date initiated: 03/10/2023.Report any inflammation, swelling, or complaints of discomfort to the physician and family. Date initiated: 03/10/2023; revised 11/30/2025.R7's County Health Department Dental Clinic Medical Consultation Request, dated 5/12/25, documents: Hold Eliquis (blood-thinning medication) for 24 hours before extractions. The same consultation documents R7 will have multiple tooth extractions. Handwritten at the bottom of the consultation sheet documents a dental appointment scheduled for 9/3/25.On 2/06/26 at 10:20 a.m., R7 stated, I do have an issue with my dental appointments. (V26), the previous van driver-he still works here, but I don't know where-has had to reschedule appointments for my dental extractions so many times I can't count. As you see, I only have three teeth on the top. The other ones are all broken, and I only have three teeth on the bottom. The others are all broken off to my gums. R7 opened his mouth. He had multiple black and brown broken teeth that appeared as nubs at the gum level. R7 had three dark brown/black upper teeth and three brown/black lower teeth. The existing six teeth were chipped. R7 stated, I have learned how to eat with these bad teeth. I have little to no pain while I wait to have them all extracted and get my dentures.On 2/06/26 at 12:10 p.m., V26, Van Driver/Scheduler, stated, During the buyout, (Private Company) took over on 01/01/26. They are trying to research the insurance and title of the facility van. We have not been able to provide transportation for residents' appointments. I have visited residents and families and rescheduled appointments. All appointments have been rescheduled for the upcoming two, three, and four weeks. Some family members did take residents to appointments. (Local public transportation service) was supposed to meet with us last week. Weather dropped into low temperatures, and the roads were slick, and they closed. They have not met with us yet, but our plan is to use them. Part of the reason R7 missed dental appointments is because the county public health department had been remodeling around Christmas. We will be working with (Local public transportation service) to try to find him transportation to get his dental work completed. It has been on hold for a couple of months. He is not happy about that, but I'm doing the best I can to get it scheduled.V9, Regional Director, provided an email dated 02/16/26 at 3:46 p.m. documenting R7's dental appointments and reasons they were rescheduled.R7's dental appointments were documented as follows:5/12/25 - first visit (attended in person)9/3/25 - rescheduled because medications were not held10/1/25 - rescheduled because insurance was canceled2/10/26 - rescheduled because transportation was unavailable2/17/26 - appointment scheduled (see interview below; also rescheduled)On 2/17/26 at 12:25 p.m., V26, Van Driver/Scheduler, and V9, Regional Director/Acting Interim Administrator, entered the conference room together. V26 reviewed the appointment list provided by V9 and confirmed its accuracy. V26 stated the facility had to reschedule R7's dental appointment scheduled for that day (02/17/26) because he (continued on next page)

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	145636	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charleston Rehab and Nursing	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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could not reach the local public transportation service for transportation. R7's appointment was rescheduled for March 5, 2026-10 months after the 5/12/25 visit when extractions were determined to be needed.V9 was present and confirmed R7's 9/3/25 appointment should have been kept, stating, The nurses should have been aware R7 was not to have the medications prior to the dental appointment. V9 also stated, About the 10/1/25 insurance issue, I will have (V49), Regional Business Office Manager, get back to you about this.On 2/17/26 at 1:05 p.m., V49, Regional Business Office Manager, stated, It was a mistake. R7 had active Medicaid coverage on 10/1/25, and he shouldn't have needed to reschedule that dental appointment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 record review and interviews, the facility failed to maintain complete and accurate medical records for two of 18 residents (R7 and R17) reviewed for accuracy of medical records on the sample list of 18.Findings include:1. R17's Minimum Data Set (MDS) dated [DATE] documents R17's BIMS score as 14 out of a possible 15, indicating no cognitive impairment.The facility reported incident, final State Report dated 01/16/26 documents that on 01/10/26 at 4:40 pm an allegation of verbal abuse was identified as follows: Resident (R16) to resident (R17) verbal exchange.There is no documentation in R17's medical record of the above resident-to-resident altercation that occurred on 01/10/26. There is no documentation that R17's crying episodes/ emotional response were being monitored.On 2/6/26 at 3:05 pm R17 stated It seems like, I have talked to a lot of people about (R16) yelling at me in the dining room. I (R17) cried and went back to my room, when he would not stop cussing at me. I thought he (R16) and I (R17) were friends. Friends don't use the F- word or tell you to shut up. I am not sure what his problem was that day. I was just hanging out in the dining room with the cooks while I waited on them to serve the food. I was overwhelmed at the time. I have depression. That, yelling profanities at me does not help. I am tearing up (observed as he talked) now just talking about the ordeal.On 2/13/26 at 9:50 am V1, Administrator/ Abuse Prevention Coordinator said the resident to resident altercation between R16 and R17 that occurred on 1/10/26 should have been documented in both residents charts. V1 stated also stated she was not aware until this time that there was no documentation in R17's medical records. V1 stated R17 should have been monitored for anxiety, fear and increased depression. 2. R7's Minimum Data Set (MDS) dated 11.28.25 documents R7 has a Brief Interview of mental Status score of 15 out of a possible 15 indicating R7 has no cognitive impairment.R7's same MDS documents R7 has no Obvious or likely cavity or broken natural teeth.R7's Care Plan updated 11.30.25 documents the following: Dental Care: (R7) has poor dentation with obvious tooth decay.On 2/06/26 at 10:20 am R7 stated he has dental issues with a plan to have all his teeth extracted and get dentures. R7, opens his mouth. R7 had multiple black and brown broken teeth that looked like nubs at the gum level. R7 has three dark brown/black colored upper teeth, and three brown/black lower teeth. R7's existing six teeth are chipped.On 2/13/26 at 11:55 am V1, Administrator confirmed R7 MDS was coded incorrectly and is incongruent with R7 other medical records and current health status. (R7) obviously has broken teeth.