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	03/12/2026

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 0684 Level of Harm - 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 recognize and respond to a significant change in condition and delayed treatment for one resident (R1) with a known Covid diagnosis and a history of Atrial Fibrillation. This failure affects one (R1) of three residents reviewed for Resident/Patient/Client Neglect. As a result of the delayed response, R1 was sent to the local hospital and diagnosed with Acute Renal Failure, Elevated Troponin, Hyperkalemia, Dehydration, and Atrial Fibrillation with Rapid Ventricular Response. Findings include:On 3/11/26 at 9:39 a.m., R1 was observed lying in bed. R1 appeared thin and fragile, with oxygen tubing in place and the concentrator running at two liters per minute.R1's Electronic Health Record (EHR) dated 6/5/25 documents a diagnosis of Paroxysmal Atrial Fibrillation.R1's Minimum Data Set (MDS) dated [DATE] documents R1's cognition is intact.R1's Care Plan dated 6/18/25 documents R1 has a diagnosis of Atrial Fibrillation. An intervention for this focus area is that staff will notify physician of any abnormal readings. R1's progress notes dated 1/31/26 document R1 exhibiting tiredness, dry cough, and fever; a Covid test was performed and was positive.R1's vital sign flow sheet dated 2/8/26 at 9:52 a.m. and 11:03 a.m. documents that V7 Registered Nurse (RN) obtained R1's vital signs and noted a new onset irregular heart rate of 111 beats per minute.On 3/11/26 at 9:43 a.m., V6, Certified Nurse Assistant (CNA) stated R1 had been ill with Covid in February and that it hit him really hard. V6 stated R1 was not breathing well, not eating, and appeared significantly off the weekend prior to R1 being sent to the hospital. V6 stated that she, V8 CNA, and V9 CNA reported their concerns to V4 LPN over the weekend, but V4 told them she was too busy to assess R1.On 3/11/26 at 11:21 a.m., V8, CNA stated that V4 LPN and V7 RN were working the weekend in February when R1 experienced a significant decline. V8 stated R1 was extremely weak, had lost the ability to care for or feed himself, repeatedly said he did not feel well, and was short of breath the day before being sent to the emergency room. V8 stated she reported this to V4, who said she was too busy with a medication pass. V8 stated the next morning R1 appeared dazed and spoke little. V8 stated that when she reported this to V4, V4 said she would get to R1 when she could. V8 stated she then went directly to V2, DON, with concerns about R1's change in condition and V4's response to her concerns.On 3/11/26 at 11:29 a.m., V9, CNA stated R1 went downhill really fast when he had Covid in February. V9 stated R1 was extremely lethargic, complained of not feeling well, and was no longer able to assist with transfers as he had before. V9 stated she along with V6 and V8 repeatedly reported concerns to V4 LPN and V7 RN, asking what could be done for R1. V9 stated V4 repeatedly said she was too busy to assess R1. V9 stated she, V6, and V7 then brought their concerns to V2, DON.On 3/11/26 at 2:20 p.m., V4, LPN stated she did not remember the details surrounding R1's illness in February that required hospitalization. V4 stated that an assessment should be completed immediately when a CNA reports that a resident is not feeling well and not acting like themselves. On 3/12/26 at 10:47 a.m., V7, RN stated she was new to the facility in January and was still learning the residents. V7 stated she does not recall obtaining vital signs for R1 during his illness. V7 stated she does recall CNAs reporting a significant change in R1's condition the weekend before he was sent to the hospital, and that they told her they had reported it to V4 LPN, who did not act on their concerns.On 3/12/26 at 9:17 a.m., V2, DON stated R1 became very (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	ill with Covid, and on the morning she assessed him and sent him to the emergency room he was very lethargic, alert and oriented only to self, which was not his baseline, and complained of generalized pain that worsened with movement, as evidenced by R1 moaning. V2 stated nurses should assess residents promptly when there are concerns regarding a change in the resident's condition. V2 stated that on the day R1's vital signs showed an elevated, irregular pulse with R1 having a history of Atrial Fibrillation, V4 LPN or V7 RN should have sent R1out for evaluation.On 3/12/26 at 9:36 a.m., V15, Physician Assistant (PA) stated that if a nurse obtained an irregular pulse of 111 that was not normal for R1, it should have been reported to the PA or R1 should have been sent to the emergency room for further evaluation. V15 stated R1's clinical picture warranted an Xˆray and EKG, and that had R1 been sent out sooner when the irregular pulse and change in cognition were identified, R1 probably would not have suffered from hypoxia, acute renal failure, dehydration, and Atrial Fibrillation with Rapid Ventricular Response. R1's hospital records dated 2/9/26 document that R1 was admitted to the local hospital with a diagnosis of Covid-19, Acute Renal Failure, Dementia, Elevated Troponin, Hyperkalemia, Dehydration and Atrial Fibrillation with Rapid Ventricular Response. The facility's Change in Condition Procedure dated 9/21/25 documents that the facility will provide guidelines for the appropriate handling of a resident's change in condition. This policy documents the following guidelines that will be utilized as appropriate to each situation and change in condition:1. Full Assessment by nursing staff including but not limited to:a. Full vitals (Temperature, Pulse, Respiration, Blood Pressure, and Oxygen Saturation)b. Level of consciousnessc. Respiratory status including lung soundsd. Abdomen including last bowel movement and urine propertiese. Functional statusf. Pain2. Staff should notify Medical Doctor of change and give assessment information.