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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145636	A. Building B. Wing	04/23/2026

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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement physician's orders for one of three residents (R1) reviewed for following plans of care on the sample list of nine. Findings Include:R1's Medical Diagnoses List dated April 2026 documents Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Hypertension, Atrial Fibrillation, and Type II Diabetes Mellitus.R1's Minimum Data Set, dated [DATE] documents R1 is cognitively intact. R1's Physician Medication Order Sheet dated April 2026 documents a physician order for nursing to wrap R1's bilateral legs with elastic compression bandages from dorsum feet to below the knee every morning and remove at bedtime. R1's Treatment Administration Record (TAR) dated April 2026 documents between 4/1/26 - 4/23/26 there were seven missed treatments for R1's leg wraps. On 4/23/26 at 3:30 PM V2 Director of Nurses confirmed nurses need to document treatments on the TAR. V2 also confirmed nurses need to notify the doctor if residents are refusing treatments and document the refusal in the medical record. V2 confirmed R1's legs need to be wrapped daily per physician order.

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

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NAME OF PROVIDER OR SUPPLIER Charleston Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Eighteenth Street Charleston, IL 61920	

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately transcribe and administer multiple medications per physician order. This failure affected two of three residents (R1, R2) reviewed for pharmaceuticals on the sample list of nine. This failure included multiple missed doses of an antiepileptic medication resulting in R2 having a seizure and subsequently being sent to the emergency room. Findings Include:1. R2's Hospital Discharge Instructions dated 2/24/26 documents R2 was discharged to the facility on 2/24/26 after a hospital admission for elevated phenytoin level, altered mental status and urinary tract infection. R2's previous Phenytoin medication order was discontinued and R2 was to start taking Phenytoin 300 milligrams daily at bedtime. R2's Medical Diagnoses List dated March 2026 documents R2 is diagnosed with Epilepsy.R2's Physician Orders from her stay in the facility from 2/24/26 through 3/16/26 does not include an order for Phenytoin.R2's Nursing Progress Note dated 3/11/26 documents R2 was found in her wheelchair, shaking and foaming at the mouth with her eyes rolled back in her head. The seizure was observed for three to four minutes. After the seizure was over R2 began to react to verbal stimuli but was not yet back to baseline when she was taken by ambulance to the hospital.R2's Emergency Documentation dated 3/11/26 documents R2 presented to the emergency department from the facility with a breakthrough seizure. R2 does have a history of epilepsy. R2 was in the hospital a few weeks prior with supratherapeutic Dilantin levels and her dose of Dilantin decreased from 350 milligrams per day to 300 milligrams per day upon discharge to the facility. However, after reviewing R2's facility records, R2 was not taking Dilantin. It was noted that R2 did have a cluster of seizures and was slowly coming back to baseline. R2's Dilantin level on 3/11/26 resulted as 1.4 micrograms per milliliter (Low). Therapeutic levels are between 10-20 micrograms per milliliter.On 4/14/26 at 1:28 PM V3 Assistant Director of Nurses (ADON) stated she was the nurse who admitted R2 and confirmed she missed the new order to start Phenytoin 300 milligrams at bedtime and did not enter this order in R2's electronic medical record.On 4/14/26 at 1:28 PM V2 Director of Nurses (DON) confirmed V3 ADON had missed the Phenytoin order upon admission and R2 never received any Phenytoin while at the facility from admission to discharge. V2 DON confirmed she did phone the hospital to clarify medication orders but did not hear back from them and did not follow through with order clarification. V2 confirmed R2 did end up having a seizure on 3/11/26 in the facility and was transferred to the hospital for evaluation and treatment. V2 confirmed R2 had a history of seizures and was on Dilantin prior to admission and the dose was changed on the admission sheet from the hospital. The medication was important to the well-being of the R2 and should have been clarified if needed and physician orders should have been followed.On 4/22/26 at 1:45 PM V16 Physician Assistant (PA) stated he was unaware R2 had orders from the hospital to start a new dose of Phenytoin and was unaware the order was missed by V3 ADON. V16 confirmed the medication would be significant to the wellbeing of R2 who has Epilepsy. V16 stated if physician orders are confusing or nurses have questions, they need to clarify the orders and follow through until they are certain the resident is getting the correct medications. If an order is missed, or a resident dose not receive an ordered medication for one reason or another, the physician should be notified.2. R1's Medical Diagnoses List dated April 2026 documents Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Hypertension, Atrial Fibrillation, and Type II Diabetes Mellitus.R1's Minimum Data Set, dated [DATE] documents R1 is cognitively intact. R1's Physician Medication Order Sheet dated April 2026 documents physician orders for Metformin (antihyperglycemic) Extended Release 500 milligrams twice daily, Apaxiban (blood thinner) five milligrams twice daily, and Empagliflozin (antidiabetic) 25 milligrams once daily. R1's Medication Administration Record (MAR) dated April 2026 documents R1 did not receive Apixaban on the evening of 4/10/26 or 4/11/26, and the morning of 4/12/26 due to the medication being unavailable. R1's MAR dated April 2026 documents R1 did not receive (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Empagliflozin and Metformin on 4/12/26, 4/14/26, or 4/15/26 due to the medications being unavailable.On 4/22/2026 at 1:05 PM, V3 Assistant Director of Nursing (ADON) stated the expectation when medications are missing during medication pass includes the nurse on duty to contact the pharmacy to obtain the medication, use the electronic medication back up system, notify the V2 DON or V3 ADON, and notify the physician. On 4/22/2026 at 2:36 PM, V17 Registered Nurse stated on 4/12/2026 she could not find R1's Empagliflozin, Metformin, and Apixaban in the medication cart and therefore they were not administered to R1. V17 confirmed she did not notify V2 DON, the Pharmacy or Physician.On 4/22/2026 at 2:40 PM, V14 Registered Nurse stated on 4/14/26 she could not find R1's empagliflozin, metformin, and apixaban in the medication cart and therefore they were not administered to R1. V14 confirmed she did not notify V2 DON, the Pharmacy or Physician.On 4/22/2026 at 3:12PM V18 Licensed Practical Nurse stated, on 4/10/26 and 4/11/26 the 8:00 PM of R1's Apixaban was not available and R1 did not receive either dose. V18 stated she did notify V2 DON. V18 stated a refill was requested with the pharmacy, however she did not call or speak to a pharmacist. V18 confirmed R1's physician was not notified of R1's missed medications.3. R1's Physician Progress Note dated 11/18/2025 documents an order change to increase R1's Dulaglutide (anti-hyperglycemia) dose from 1.5 milligrams (mg) subcutaneously every Friday to 3 milligrams. The order was not updated in R1's physician orders.R1's Electronic Medical Record documents an order was received via facsimile dated 3/20/2026 at 1:30 PM to increase the dose of R1's Dulaglutide from 1.5 mg to 3 mg, as ordered previously in November 2025. The order was still not updated in R1's physician orders.On 4/22/2026 at 2:35 PM, V24 (Endocrinology Nurse) stated the Dulaglutide order change had been sent with R1 after his appointment in November 2011 and was again sent via facsimile to the facility in March 2026.On 4/22/2026 at 1:08 PM, V22 (Facility Driver) stated that when residents are returned to the facility from a physician appointment, the physician orders and progress notes are copied and distributed to V2 (DON), V3 (ADON), V21 (Medical Data Set Nurse, MDS), V23 (Medical Records), and the nurse on duty. On 4/23/2026 at 11:45 AM, V3 (ADON) stated the expectation for medication change orders are to be entered in by the nurse on duty at the time the order is received. R1's MAR dated November 21, 2025, through April 17, 2026, documents administration of Dulaglutide 1.5mg subcutaneous one time every Friday.On 4/23/2026 at 2:00 PM, V3 (ADON) confirmed between November 21, 2025, and April 17, 2026, R1 had received the wrong dose of Dulaglutide.The facility's Medication Error policy dated 11/5/19 documents the facility shall ensure mediations will be administered according to physician's orders. Medication errors can include the wrong person, wrong drug, wrong dose, wrong time, and wrong route.