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	05/13/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete initial and weekly pressure ulcer assessments, initiate timely wound treatments, failed to provide pressure ulcer treatments, and failed to use the physician ordered treatment for one of three residents (R5) reviewed for Quality of Care on the sample list of five. These failures resulted in R5 developing one facility acquired pressure wound which deteriorated and became infected causing R5 to be hospitalized and treated for Sepsis related to a severe wound infection. Findings Include: The facility's Skin Prevention, Assessment and Treatment policy dated 5/2/25 documents the facility's policy is in place to promote a systemic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown as well as to promote the healing of existing pressure ulcers. All residents should have their skin integrity examined thoroughly at least weekly by a licensed nurse to identify existing pressure ulcers. Findings from these weekly skin assessments should be documented on the skin progress notes. Upon identification of the development of a pressure wound, the wound assessment and treatments will be documented in the medical record and start the weekly wound log. The wound nurse should track the residents who have been identified as high risk and should create an assessment and documentation schedule. Residents with wounds should be reviewed during weekly risk management committee meetings for progress, interventions, and care plan revisions as appropriate. The Risk Management Committee should also monitor to ensure the facility's policies and protocols are followed. At the direction of the facility's Quality Assurance (QA) Committee, a weekly wound report should be completed by the Director of Nurses on a weekly basis for review and monitoring by the QA Committee to assure the objectives of the policy and protocol are being met. R5's Care Plan dated 3/6/26 documents R5 was admitted on [DATE] and is diagnosed with Paraplegia, Personal History of Infectious and Parasitic Diseases, Personal History of Methicillin Resistant, Staphylococcus Aureus Infections, and Need for Assistance with Personal Care. R5 has the potential for skin impairment due to immobility related to Paraplegia. R5 has current alterations to his skin due to a Pressure Ulcer. Staff are to conduct routine wound assessments, administer medications and apply treatments as ordered by the physician, monitor and document the location and size, and follow the facility's policies and protocols for skin breakdown. R5's Minimum Data Set, dated [DATE] documents R5 is cognitively intact and was admitted with one stage three pressure ulcer. R5's Braden Scale for Predicting Pressure Sore risk dated 2/28/26 documents R5 was at high risk due to a slightly limited ability to respond meaningfully to pressure related discomfort, bedfast, very limited mobility, probable inadequate nutrition, and a potential problem for friction and shear. R5's Wound Log dated 2/28/26 documents upon admission R5 had one stage three pressure ulcer on his left buttock/coccyx area with some tunneling. This was the only completed Wound Log. R5's Weekly Nursing Skin Review dated 2/28/26 documents upon admission R5 had one open area to his coccyx/left inner buttock with tunneling. This was the only completed Weekly Nursing Skin Review. R5's Physician Order Sheet dated March 2026 documents an order for wound treatments for the pressure ulcer on R5's coccyx and one for a new wound on R5's Left lower buttock. Both wound treatment orders began on 3/7/26. No previous wound treatment orders were initiated from R5's (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	admission on [DATE] through 3/7/26. R5's Treatment Administration Records dated March 2026 document staff did not complete wound/skin treatments for all of R5's wounds a total of 80 times. R5's Treatment Administration Records dated April 2026 document staff did not complete wound/skin treatments for all of R5's wounds a total of 54 times. R5's Wound Assessment and Plan dated 3/17/26 documents wound assessments completed by V13 Wound Nurse Practitioner. V13 documented R5 had a facility acquired left gluteal pressure ulcer on 3/6/26 which was unstageable due to the wound bed being 100% slough. On 3/17/26 this wound measured 4 centimeters (cm) length x 4 cm width x utd (unable to determine) depth. V13 ordered a wound treatment of nickel thick layer of Santyl (enzymatic wound debridement) followed by a dressing. R5's Wound Assessment and Plan dated 4/14/26 documents wound assessments completed by V13 Wound Nurse Practitioner. V13 documented R5's facility acquired left gluteal pressure ulcer measured 3.5 centimeters (cm) x 6 cm x utd (unable to determine) This wound had deteriorated and grown in size. V13 continued to order a wound treatment of nickel thick layer of Santyl (enzymatic wound debridement) followed by a dressing. V13 also ordered Bactrim for R5's wound due to signs of infection. R5's Nursing Progress Note dated 4/14/26 documents R5's wounds were leaking extensively and there were two new spots on right upper leg close to his scrotum. R5 was sent to the emergency room for evaluation. R5's Hospital Records dated 4/24/26 document R5 was admitted to the hospital on [DATE] for Sepsis secondary to an infected stage four left gluteal pressure ulcer which required a surgical debridement down to the bone. R5's wound was infected with MRSA, Morganella Morganii, E Coli, Klebsiella Pneumoniae, and Group B Streptococcus. R5 also had a perirectal abscess and Moisture Associated Skin Damage. On 5/8/26 at 1:55 PM, V5 Licensed Practical Nurse stated R5's wound treatment order was for Santyl on his left gluteal wound however because his insurance would not pay for it, she was told to use medical honey instead. V5 stated when doing R5's wound dressing changes, she thought the left gluteal wound appeared infected, had an odor and had deteriorated over a couple weeks. On 5/13/26 at 12:45 PM V12 Previous Assistant Director of Nurses (ADON) stated she completed R5's admission, is not sure why she only documented one wound, and it must've been a mistake. V12 stated she does not remember there being wound treatment orders for R5's wounds on admission and is not sure why none were ordered for him until 3/7/26 (8 days post admission). V12 stated R5 did acquire a new wound to the left gluteal on 3/6/25. V12 stated the left gluteal wound deteriorated. V12 confirmed V13 Wound Nurse Practitioner ordered Santyl for R5's wounds however R5's insurance did not cover the treatment, so she told the nursing staff to use medical honey instead. This was a PRN (as needed) order. V12 stated on 4/14/26, V12 and V13 noticed new areas where fluid was leaking from and V13 ordered an antibiotic for R5. On 5/13/26 at 1:35 PM V13 Wound Nurse Practitioner stated she started seeing R5 on 3/17/26 for multiple wounds. V13 confirmed she was told the left gluteal wound was facility acquired and began on 3/6/26. V13 stated overtime, the left gluteal wound deteriorated and eventually appeared to have tunneled into another wound with a possible abscess and was infected. V13 stated she ordered antibiotics but R5 went to the hospital the next day for his wound infection. V13 stated she was not aware that the facility nurses were using medical honey instead of the Santyl that she ordered for wound treatments. V13 stated she would expect the nursing staff to complete weekly skin and wound assessments, complete all treatment orders per physician order, and wounds should be fully documented upon admission and have treatment orders in place right away. On 5/13/26 at 12:00 PM V2 Director of Nurses confirmed R5's wounds were not completely documented upon his admission and subsequent wound assessments were not done completely. V2 also confirmed R5 did not have wound treatment orders in place until 3/7/26 which was eight days past his admission. V2 also confirmed nurses should be completing all treatments per physician order and should be documenting them in the residents' Treatment Administration Record. V2 confirmed a lack of wound prevention measures, including initial treatment, ongoing assessments and consistent wound treatments put R5 at risk for developing the facility acquired left gluteal wound. The lack of these things also put R5 at risk for developing a wound infection. V2 confirmed R5 was (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	sent to the emergency room on 4/15/26 when his left gluteal wound appeared infected. R5 was admitted for a wound infection and did not return to the facility.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to accurately document medication administration for one of three residents (R1) reviewed for pharmacy records on the sample list of five. Findings Include: R1's Physician Order dated 4/9/26 documents R1 was prescribed Ertapenem Sodium (antibiotic) one gram intramuscularly once per day for a Urinary Tract Infection for seven doses. R1's Medication Administration Record dated April 2026 documents R1 received the Ertapenem starting on 4/11/26 and ending on 4/18/26 for a total of eight documented doses. On 5/13/26 at 3:00 PM R1 stated he was not given one dose of his antibiotic back in April. He complained about it and the nurse on duty reported it. R1 stated he was told it had been confirmed by V2 Director of Nurses, after a medication count, that he had not received the dose on 4/13/26 and they would add a dose on the end and make sure he received all seven doses as prescribed.On 5/13/26 at 12:00 PM V2 Director of Nurses (DON) confirmed although the MAR documents eight doses were administered, it was found that staff had documented the dose was given when in fact it was not. V2 confirmed R1 had complained about not getting his dose on 4/13/26 and a medication count was completed that confirmed he had not received that day's dose. To provide R1 with the prescribed seven doses, a day was added at the end. V2 confirmed that R1 missed one dose on 4/13/26 but did receive seven total doses in all. V2 confirmed nurses need to document medication administration accurately and only document a medication as given if in fact the medication was administered to the resident as ordered.