

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001016		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Charleston Rehab and Nursing				STREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET , CHARLESTON, Illinois, 61920			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Complaint Investigation: 2661832/2740680		S0000			03/23/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.		S9999			03/23/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Regulations are not met as evidenced by: 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. 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 2/19/26 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.		S9999				

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S9999	Continued from page 2 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			S9999			

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S9999	Continued from page 3 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 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 R1 out 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 X ray 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 consciousness c. Respiratory status including lung sounds d. Abdomen including last bowel movement and urine		S9999				

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S9999	Continued from page 4 properties e. Functional status f. Pain 2. Staff should notify Medical Doctor of change and give assessment information. (A)		S9999				