STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145791	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fireside House of Centralia	1030 Martin Luther King Blvd Centralia, IL 62801

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure a cognitively impaired resident was adequately supervised to prevent her exiting the facility without staff knowledge for 1 (R1) of 3 residents reviewed for accidents and supervision in the sample of 3. This failure resulted in R1, who has a diagnosis of dementia and was already on 15-minute visual checks for previous exit seeking behavior, exiting the facility at an unknown time without staff knowledge or supervision, walking approximately 1.3 miles away from the facility and was found by two unknown teenage female citizens who took R1 to the local emergency room. This failure resulted in an Immediate Jeopardy, which was identified to have begun on 5/15/2025 at approximately 7:45pm when R1 exited the facility and was found by two teenage girls approximately 1.3 miles from the facility. V1 (Administrator) was notified of the Immediate Jeopardy on 5/21/2025 at 4:30pm. The surveyor confirmed by observation, record review and interview that the immediacy was removed on 5/22/2025. Findings include: R1's Facility admission Record documented R1 was admitted to this facility on 4/13/2025 with diagnoses of Parkinsonism and unspecified dementia among others. R1's MDS (minimum data set) dated 4/19/2025 documented R1 with a BIMS (brief interview for mental status) score of 6 out of 15 total which indicates R1 has severe cognitive impairment. R1's admission elopement evaluation (dated 4/13/2025) documented R1 with an elopement risk score of 0.0 which indicated no elopement risk. A progress note dated 5/13/2025 in R1's electronic health record documented R1 had attempted to leave the facility multiple times and was placed on 15-minute visual checks. On 5/21/2025, V18 (Licensed Practical Nurse/LPN) said she was the nurse caring for R1 on 5/13/2025 when R1 attempted to leave the facility without staff. V18 said R1 may use a wheelchair to get about the facility but R1 can walk well. V18 said R1 was attempting to leave the facility via the front door and was spotted by V17 (LPN) and brought back inside the facility and placed on 15-minute visual checks. V18 said at this facility the nurses are responsible for performing and documenting the 15-minute visual checks. On 5/13/2025, R1 was re-evaluated for elopement risk and scored a 3 which indicates R1 is an elopement risk. R1's care plan was updated 5/13/2025, to include 15-minute visual checks for attempted elopements from the facility. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A form titled Long Term Care Facility Serious Injury Incident and Communicable Disease Report dated 5/16/2025 documented on 5/15/2025 at 8:15pm, R1 had exited the facility without staff knowledge even though R1 was on 15-minute visual checks. The report documented R1 became upset with another resident and decided to go home, left the facility, and was assisted by two juveniles and taken to the local hospital. On 5/16/2025 at 12:05pm, V13 (Hospital Registered Nurse) said on 5/15/2025 around 8:00pm, two unknown teenage females brought R1 into the local emergency room for help. V13 said the teenagers found R1 lying in the ditch next to the cemetery. V13 said the teenagers did not know R1 and she did not get the teenagers names. V13 said R1 was not injured and thus was not actually registered as a patient that evening. V13 said the local police were called to assist in identifying where R1 belonged but a policeman did not come to the hospital and a report was not completed as far as she knew. V13 said R1 eventually told them her name and birthday and they were able to look R1 up in the hospital's computer system. V13 said she was able to find R1 in the computer system and located a working phone number for R1's son (V15/Family). V13 said she called V15 around 9:15pm and learned R1 lived at the local nursing home. V13 said she called the nursing home at 9:20pm and requested them to come pick up R1. V13 said when R1 was brought into the hospital that evening, R1 was wearing a turtleneck sweater, jeans, and a coat, but the weather was very warm that night. On 5/21/2025 at 10:15am, V15 (Family) said on 5/15/2025 at 9:15pm, he received a call from V13 (Hospital Registered Nurse) to report R1 had been brought into the local hospital by two teenage girls after being found in a ditch near the local cemetery about a mile away from the nursing home. V15 said R1 was not hurt. V15 said R1's previous home is next to the cemetery where she was found. V15 said he told V13 that R1 lived at the nursing home. V15 said V13 called the nursing home, and the nursing home staff came to the hospital and picked up R1. On 5/21/2025 at 10:00am, V14 (Licensed Practical Nurse/LPN) said she was the nurse providing care for R1 during the day on 5/15/2025. V14 said she did not know R1 had previously attempted to leave the facility without staff on 5/13/2025 and was placed on 15-minute visual checks. V14 said this information was not passed on to her in shift report and she had been off for a few days. V14 said since she did not know R1 was on 15-minute visual checks, she did not perform the checks and did not pass this information on to the next nurse on duty which was V3 (Registered Nurse/RN). On 5/21/2025 at 10:30am, V3 said she, V6 (Certified Nursing Assistant/CNA) and V8 (CNA) were the staff providing care for R1 on the evening of 5/15/2025. V3 said she did not know R1 was on 15-minute visual checks as this information was not passed on to her in shift report. V3 said since she did not know R1 was on 15-minute visual checks, she was not performing the checks on the evening of 5/15/2025 when R1 left the facility without staff knowledge. V3 said she last remembered seeing R1 in her room around 7:30pm. V3 said she did not know R1 was missing from the facility until the hospital called the nursing home about 9:15pm to report R1 was at the hospital, needed picked up and was not injured. V3 said she sent V6 over to the hospital to pick up R1 and return her to the nursing home. V3 said after R1 returned to the facility she discovered R1 was already supposed to be on 15-minute visual checks and completed the 15-minute visual check sheet at that time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/21/2025 at 2:15pm, V6 said she worked on R1's unit the evening of 5/15/2025. V6 said she had not worked for a few days and did not know R1 had attempted to leave the facility without staff on 5/13/2025 and was placed on 15-minute visual checks. V6 said this information was not passed on to her in shift report. V6 said the nurses are responsible for performing and documenting the 15-minute visual checks so she did not know anything about it. V6 said on 5/15/2025 the last time she remembered seeing R1 at the facility was around 7:30pm and R1 was in her room. V6 said she did not know R1 was missing from the facility until V3 (RN) received a call from the hospital around 9:15pm. V6 said she was sent to the hospital to get R1 and bring her back to the facility. On 5/21/2025 at 2:45pm, V8 said she worked R1's unit the evening of 5/15/2025. V8 said she had been off for a few days and did not know R1 had attempted to leave the facility without staff on 5/13/2025 and was placed on 15-minute visual checks. V8 said the nurses perform the 15-minute checks so she had no knowledge of R1 being on 15-minute visual checks. V8 said on 5/15/2025, she returned from her lunch break around 7:45pm and she seen R1 in her room. V8 said she did not know R1 was missing from the facility until 9:15pm when V3 (RN) received a phone call from the hospital reporting R1 was there without staff. On 5/21/2025 at 2:20pm, V5 (CNA) said she was working the evening of 5/15/2025 but was not on R1's unit. V5 said she did not know R1 was on 15-minute visual checks for elopement attempts. V5 said every evening between 6:00pm and 8:30pm the facility's door alarm is constantly alarming due to family members coming in and out of the facility. V5 said on 5/15/2025 around 7:30pm, she noticed the facility's front door alarm sounding and no one was around. V5 said she looked outside of the front door and did not see anyone. V5 said she reset the alarm and returned to work without telling any other staff about the alarming door. V5 said she feels this could be when R1 left the facility. V5 said she found out later that night around 9:30pm that R1 was missing from the facility after the hospital called to report R1 was at the hospital without staff. On 5/22/2025 at 1:45pm, R1 was observed walking with a wheeled walker with V16 (Physical Therapy Assistant) around the facility. R1 easily walked with a steady gait and lifted up and carried the wheeled walker when going over thresholds without losing her balance. V16 said R1 can walk very well and doesn't really need to use a wheelchair. V16 said on good days, R1 walks me instead of me walking R1. The facility's 24-Hour Report sheet for R1's unit dated 5/13/2025 documented R1 was started on 15-minute visual checks and the dressing to R1's left thumb was changed. The facility's 24-Hour Report sheet for R1's unit dated 5/14/2025 documented R1's dressing to the left thumb was changed and did not include any information about R1 being on 15-minute visual checks. The facility's 24-Hour Report sheet for R1's unit dated 5/15/2025 documented R1 had a new medication order and did not include any information about R1 being on 15-minute visual checks. R1's 15-minute visual check sheets dated 5/15/2025 documented V3 observed R1 in her room at 8:00pm. At 8:15pm, a question mark was documented for R1's location by V3. At 8:30pm, hosp (hospital) was documented for R1's location by V3. At 8:45pm, hosp was documented for R1's location by V3. At 9:00pm, hosp was documented for R1's location by V3. At 9:15pm, hosp was documented for R1's location by V3. At 9:30pm, R1 was documented in her room by V3. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An undated facility policy titled Facility Door Alarms under the section titled Procedure For Response To Sounding Door Alarm documented Nurse or designee will identify the location of the door alarm triggered. The nurse or designee will notify the appropriate nursing station. The nurse or designee will go to identify the exit and verify reason for the triggered alarm. If the reason for the sounding alarm is not identified, the location of all residents known as a Wander/Elopement Risk will be verified. At no time will the sounding door alarm be canceled before verification is confirmed. An undated facility policy titled Wandering and Elopements documented the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for the resident and if on 15-minute visual (checks) put on 24-hour report (sheet) until d/c'd (discontinued). The Immediate Jeopardy that began on 5/15/2025 was removed on 5/22/2025 when the facility took the following actions to remove the immediacy and correct the noncompliance. On 5/15/2025 at 9:30pm, R1 returned to the facility and was placed on 1:1 monitoring which continued until 5/16/2025 at 7:45am when an exiting alarm device was placed on R1's wrist. R1 continues on 15-minute visual checks. All staff, including department heads, have been educated to ensure that they are aware of policy related to resident elopement, wandering and 15-minute visual checks. Education was provided by V11 (Assistant Director of Nursing) and was completed on 5/15/2025 and 5/22/2025, with education on-going. On 5/22/2025 a Quality Assurance and Performance Improvement meeting was held and the plan of correction and implementation was documented as follows: 1. The facility reviewed the policy and procedures for door alarms, 15-minute visual checks. Missing residents, and elopements. (Staff) to make sure anyone on 15-minute visual checks is placed on the 24-hour report sheets daily. All reviewed with staff. 2. All residents at risk for elopement were reassessed. 3. All residents who are elopement risk will be reassessed as necessary. 4. Monitor door alarms for staff properly following protocol. 5. V1 (Administrator) in-serviced staff, Assistant Director of Nursing, and all department managers. 6. V1 ensured residents, who are identified as high elopement risk, have updated and correct information about them in the facility's elopement book at both nurses' stations. 7. Monitor staff for compliance with door alarm procedure. 8. Review nursing for completing assessments on high elopement risk residents. 9. Director of Nursing or Designee to monitor all for compliance weekly for two weeks.