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	12/12/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on observation, interview and record review the facility failed to provide feeding assistance for dependent residents in a way that promoted dignity for 2 out of 2 residents (R11, R23) reviewed for dignity in a sample of 35. Findings include: 1. R11's admission record documents an admitted [DATE] with the following diagnoses in part; Alzheimer's disease, unspecified and dysphagia, oropharyngeal stage. R11's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 04, indicating R11 is severely cognitively impaired. Section GG- functional abilities documents that R11 requires assistance with eating. On 12/09/24 at 12:31pm, V16 (Certified Nurse Aide/CNA) was observed standing over R11 while providing eating assistance. On 12/09/24 at 12:37pm, V16 was observed using R11's clothing protector to clean food off R11's mouth. On 12/10/24 at 12:28pm, V16 was observed standing over R11 while providing eating assistance. 2. R23's admission record documents an admitted [DATE] with the following diagnosis in part; vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R23's Minimum Data Set (MDS) dated [DATE] documents a BIMS was not completed, because resident is rarely/never understood. Section GG- functional abilities documents that R23 is dependent on staff for eating. On 12/09/24 at 12:30pm, V7 (CNA) was observed standing over R23 while trying to provide eating assistance. On 12/09/24 at 12:37am, V7, V15, V16, V17 (CNA's) were assisting residents with their meals, and were talking amongst themselves and not engaging residents. V7 (CNA) had earbuds in. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 1:34pm, V2 (DON) stated she would expect CNA's to be seated next to residents they are providing assistance for meals, not standing. V2 also stated it was her expectation that staff would be engaging residents in conversation, not other staff.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview and record review, the facility failed to ensure an individual admitted with a mental illness diagnosis was referred to the appropriate state-designated authority for a Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination of need for any specialized service for 2 of 3 residents (R32 and R35) reviewed for PASARR requirements in a sample of 35. Findings include: 1. R32's Admission Record dated 12/11/24 documents an admitted [DATE]. R32's diagnosis report dated 12/12/24 documents Bipolar II disorder with a onset date 07/15/20 and Major Depressive Disorder recurrent with a onset of 07/15/20. R32's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 13 which indicates that R32 is cognitively intact. Section I under Active diagnoses list anxiety disorder, depression, and bipolar disorder. R32'S OBRA (Omnibus Budget Reconciliation Act) I Initial Screen/Interagency Certification of Screening Results, dated 03/29/2021, documents the following under Reasonable Basis to Suspect a Mental Illness The individual has been formally diagnosed with a mental illness which substantially impairs the person's cognitive, emotional and/or behavioral functioning is checked No. The individual has a history of psychiatric hospitalization is checked No The individual has a history of outpatient mental health services No There are other indicators of mental illness No. Specify other indication is blank. On 12/11/2024 at 3:30pm, V8 (Business Office Manager) said he reached out to the agency that performs PASARR (pre-admission screening and resident review) assessments and requested the agency perform another assessment on R32 since the previous one was incorrect. V8 said R32 does have qualifying diagnosis of bipolar, however the screening agency was not aware of this information. V8 said the facility missed notifying the screening agency but should have. 41610 2. R35's Admission Record documents an original admitted [DATE]. R35's Minimum Data Set (MDS) dated [DATE] documents: an active diagnosis of schizophrenia. R35's medical record contains no documentation of a Level II PASARR. R35's Preadmission Screening and Resident Review dated 04/28/22 documents: screening indicated nursing facility services are appropriate. This document does not contain a diagnosis of schizophrenia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 10:45 V8 (Business Office Manger) stated the PASSAR Level 1 is all they have for R35, he has not been in this position long, so R35 does not have a Level II PASARR. The Facility policy titled Admission Criteria with a revision date of December 2016 documents under policy interpretation and implementations 8. Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordinator with the Medicaid Pre-Admission Screening and Resident Review program (PASARR) to the extent practicable. 9. Potential residents with mental disorders or intellectual disabilities will only be admitted if the State mental health agency has determined (through the preadmission screening program) that the individual has a physical or mental condition that requires the level of services provided by the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation and record review the facility failed to provide the correct textured diet as ordered for 4 of 17 residents (R8, R20, R41, and R47) reviewed for meal texture in the sample of 35. Findings include: The facility document titled, Daily Spreadsheet dated Monday 12/09/2024 documents: regular diet: spaghetti with meat sauce 1/2 cup/6 oz (ounces), Caesar salad 1 cup, garlic bread 1 slice, and ambrosia #8 scoop. The easy to chew diet documents: spaghetti with meat sauce 1/2 cup/6 oz (ounces), chilled steamed vegetables 1/2 cup, soft and buttered bread, and mandarin oranges #8 scoop. 1. R47's Admission record documents: an admitted [DATE] with diagnoses including: chronic kidney disease, vitamin D deficiency, Vitamin B12 deficiency, anemia, and muscle weakness. R47's MDS dated [DATE] documents a BIMS score of 10 indicating R47 is moderately impaired. R47's Physicians order sheet documents a dietary order of: regular diet, easy to chew (mechanical soft) texture, regular/thin liquids consistency, no straws, HFBP (high fiber bowel program) 8 oz (ounces) extra fluids TID (three times a day) with meals, ice cream 1 x (time) daily with meal with an active date of 07/11/2024 at 12:28 PM. On 12/09/24 at 11:40 AM, R47 received spaghetti with meat sauce 1/2 cup/6 oz (ounces), beets 1/2 cup, toasted garlic bread 1 slice and ambrosia #8 scoop. 2. R8's admission sheet documents an admitted [DATE] and diagnoses including: type 2 diabetes mellitus, dementia, vitamin D deficiency, magnesium deficiency, muscle wasting and atrophy, and muscle weakness. R8's Physicians order sheet documents a diet order of: regular diet, easy to chew (mech soft) texture, regular/thin liquids consistency, 8 oz extra fluids TID (three times a day)with meals, HS (evening) snack, High Fiber, double protein with meals for nutrition with an active date of 07/11/2024 at 2:30 PM. On 12/09/24 at 11:40 AM, R8 received spaghetti with meat sauce 1/2 cup/6 oz (ounces), beets 1/2 cup, toasted garlic bread 1 slice and ambrosia #8 scoop. 3. R20's Admission Sheet documents an admitted [DATE] with diagnoses including: Parkinson's disease, multiple fractures of ribs, vitamin B12 deficiency, anemia, muscle weakness and dysphagia. R20's Physician's order sheet documents an dietary order dated 08/06/24 for regular diet, easy to chew (mech soft) texture with regular/thin liquid consistency. On 12/09/24 at 11:40 AM, R20 received spaghetti with meat sauce 1/2 cup/6 oz (ounces), beets 1/2 cup, toasted garlic bread 1 slice and ambrosia #8 scoop. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R41's Admission Record documents an admitted [DATE] with diagnoses including: muscle wasting and atrophy, dysphagia, and Parkinsonism. R41's Physicians order sheet documents a dietary order dated 10/01/24 for regular diet, easy to chew texture, regular/thin liquid consistency with double protein at meals. On 12/09/24 at 11:40 AM, R41 received spaghetti with meat sauce 1/2 cup/6 oz (ounces), beets 1/2 cup, toasted garlic bread 1 slice and ambrosia #8 scoop. On 12/12/24 at 1:05 PM, V14 (Dietary Manager) V14 stated the diets should be followed as directed by the spreadsheet. The mechanical soft diets should not have received the ambrosia salad or the toasted garlic bread. The facility policy titled, Diet Descriptions dated 04/26/2023 documents 3. Texture modified diets and thickened liquids - texture modified diets are prepared and served as prescribed by the physician or community speech language pathologist when a resident has difficulty chewing and/ or swallowing.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation, and record review the facility failed to provide extra supplementation as ordered for 4 of 17 residents (R8, R45, R47, and R56) reviewed for dietary supplementation in the sample of 35. Findings include: 1. R47's Admission record documents: an admitted [DATE] with diagnoses including: chronic kidney disease, vitamin D deficiency, Vitamin B12 deficiency, anemia, and muscle weakness. R47's minimum data set (MDS) dated [DATE] documents a brief interview of mental status (BIMS) score of 10 indicating R47 is moderately impaired. R47's Physician's order sheet documents a dietary order with an active date of 07/11/2024 at 12:28 PM of: regular diet, easy to chew (mechanical soft) texture, regular/thin liquids consistency, no straws, HFBP (high fiber bowel program) 8 oz (ounces) extra fluids TID (tree times a day) with meals, ice cream 1 x (time) daily with meal. On 12/09/24 at 11:40 AM, R47 received her lunch in her room with no ice cream given. On 12/10/24 at 11:45 AM, R47 received her lunch in her room with no ice cream given. On 12/11/24 at 11:48 AM, R47 received her lunch in her room with no ice cream given. On 12/11/24 at 12:20 PM, R47 stated, she receives ice cream a few times a week but not every day. R47's care plan documents a focus area documenting in part: R47 has actual/potential alteration in nutritional or hydration status with an intervention listed as ice cream one time daily with meal dated 04/22/24. 2. R56's admission record documents an admitted [DATE] with diagnoses including: muscle weakness, dementia, and dysphagia. R56's MDS dated [DATE] documents no BIMS assessment was performed due to resident is rarely to never understood. R56's Physician order sheet documents a dietary order with an active date of 07/11/24 at 12:43 PM of: regular diet, pureed texture, mildly thick (nectar) consistency, HFBP, nutritional ice cream with lunch, 8 oz. cranberry juice with all meals, and prune juice with breakfast. On 12/09/24 at 11:40 AM, R56 received her lunch in the dining room with no nutritional ice cream given. On 12/10/24 at 11:45 AM, R56 received her lunch in the dining room with no nutritional ice cream given. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 11:48 AM, R56 received her lunch in the dining room with no nutritional ice cream given. R56's care plan documents a focus area documenting in part: R56 has actual/potential alteration in nutritional or hydration status with an intervention listed as nutritional ice cream with lunch dated 04/01/24. 3. R45's Admission Record documents an admitted [DATE] with diagnoses including: type 2 diabetes mellitus with diabetic neuropathy, muscle weakness, and dementia. R45's MDS dated [DATE] documents a BIMS score of 07, indicating resident's cognition is severely impaired. R45's Physician order sheet documents a dietary order of: regular diet, regular texture, regular/thin liquids consistency with juice and milk at all meals and ice cream daily with active date of 03/20/2024. On 12/09/24 at 11:40 AM, R45 received his lunch in the dining room with no ice cream given. On 12/10/24 at 11:45 AM, R45 received his lunch in the dining room with no ice cream given. On 12/11/24 at 11:48 AM, R45 received his lunch in the dining room with no ice cream given. On 12/11/24 at 1:15 PM, R45 stated he gets ice cream sometimes. 4. R8's admission sheet documents an admitted [DATE] and diagnoses including: type 2 diabetes mellitus, dementia, vitamin D deficiency, magnesium deficiency, muscle wasting and atrophy, and muscle weakness. R8's MDS dated [DATE] documents a BIMS score of 09 indicating moderately impaired. R8's Physician order sheet documents a diet order of: regular diet, easy to chew (mech soft) texture, regular/thin liquids consistency, 8 oz extra fluids TID (three times a day) with meals, HS (evening) snack, High Fiber, double protein with meals for nutrition with an active date of 07/11/2024 at 2:30 PM. R8's care plan documents a focus area documenting in part: R8 has actual/potential alteration in nutritional or hydration status with an intervention listed as double protein with meals dated 04/04/24. The facility document titled, Daily Spreadsheet dated Monday 12/09/2024 documents: regular diet: spaghetti with meat sauce 1/2 cup/6 oz (ounces), Caesar salad 1 cup, garlic bread 1 slice, and ambrosia #8 scoop, the easy to chew diet documents: spaghetti with meat sauce 1/2 cup/6 oz (ounces), chilled steamed vegetables 1/2 cup, soft and buttered bread, and mandarin oranges #8 scoop. On 12/09/24 at 11:40 AM, while in the dining room R8 received spaghetti with meat sauce 1/2 cup/6 oz (ounces), beets 1/2 cup, toasted garlic bread 1 slice, and ambrosia #8 scoop. There was no double protein placed on R8's lunch tray. The facility document titled, Daily Spreadsheet dated Tuesday 12/10/2024 documents: easy to chew diet: breaded pork chop 3oz, au gratin potatoes #8 scoop, honey glazed baby carrots (soft) #8 scoop, bread or roll with butter or margarine 1 each (soft and buttered), and frosted brownie 3x2 soft. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/24 at 11:45 AM, R8 received breaded pork chop 3oz, au gratin potatoes #8 scoop, honey glazed baby carrots (soft) #8 scoop, bread or roll with butter or margarine 1 each (soft and buttered), and frosted brownie 3x2 soft. R8 received his lunch without a double protein given. The facility document titled, Daily Spreadsheet dated Wednesday 12/11/2024 documents: easy to chew diet: fried chicken (remove bone) 3oz, mashed potatoes #8 scoop, gravy 1 oz, chilled steamed vegetables soft #8 scoop, bread or roll with butter or margarine 1 each (soft and buttered), vanilla butter cake 3x2. On 12/11/24 at 11:48 AM, R8 received fried chicken (remove bone) 3oz, mashed potatoes #8 scoop, gravy 1 oz, chilled steamed vegetables soft #8 scoop, bread or roll with butter or margarine 1 each (soft and buttered), vanilla butter cake 3x2. R8 received his lunch without a double protein given. On 12/11/24 at 1:05 PM, R8 stated he does not know if he receives double protein. On 12/12/24 at 1:05 PM, V14 (Dietary Manager) stated R47 is supposed to receive ice cream with lunch as a supplement for weight, she does have a BMI below normal limits and she does not remember when her last intervention was. R56 is supposed to receive a nutritional ice cream with lunch, R45 is suppose to receive ice cream with lunch. R8 is supposed to receive double protein and he should have received it. V14 stated she does not know why they did not receive those items. All residents that have an order for additional protein, food item, or supplement should receive it. The facility policy dated 09/16/2018 titled, Nourishments documents: policy: nourishments or additional snacks should be provided to offer therapeutic nutritional support.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39744 Based on observation, interview and record review, the facility failed to maintain infection control practices in accordance with current standards of practice during patient care for 8 of 8 residents (R8, R16, R24, R28, R32, R41, R64, R65) reviewed for infection control in the sample of 35. Findings include: 1. On 12/10/2024 at 7:40am, V4 (Registered Nurse) was observed sanitizing her hands before preparing R64's morning medications. V4 placed R64's pills in pudding and fed them to R64. R64 spit out the pills and V4 collected them in a drinking cup. V4 returned to the medication cart and began preparing R64's medications again. V4 did not wash her hands or perform hand sanitation. After administering R64's pills a second time, V4 went to the medication cart to prepare medications for R32 and did not wash her hands or perform hand sanitation. V4 administered R32's medications. V4 returned to her medication cart to prepare the next resident's medications and did not wash her hands or perform hand sanitation. V4 noticed the bandage to R64's left elbow needed to be changed and was hanging half off. V4 gathered the needed supplies from the nearby treatment cart and laid them on a bedside table located next to the medication cart and near R64. V4 did not wash her hands or perform hand sanitation and did not sanitize the table or place a clean barrier on the table before laying her supplies down. V4 donned gloves, removed R64's old dressing, cleansed the wound and applied the clean dressing. V4 then placed the bedside table in front of R64. At 8:15am, R64 was served his breakfast tray on the same bedside table that had not been cleansed since being used for the dressing change. V4 returned to the medication cart, did not wash her hands or perform hand sanitation and prepared R24's morning medications. V4 administered R24's medications, returned to the medication cart and did not wash her hands or perform hand sanitation. On 12/12/2024 at 7:45am, V2 (Director of Nursing) said V4 should have washed her hands or performed hand sanitation before and after administering medications. V2 said V4 should have cleansed the bedside table or placed a clean barrier down before using the table for dressing change purposes. V2 said the bedside table should have been cleansed and sanitized before R64 was served his breakfast on it. On 12/12/2024 at 8:00am, V6 (Licensed Practical Nurse) said hand sanitation before and after patient medication administration is not only the facility's policy she considered it to be standard of care for all healthcare workers. Facility policy titled Administering Medications, revision date of December 2012, documented the follow: Staff shall follow established facility infection control procedures of handwashing, antiseptic technique, gloves, isolation precautions for the administration of medications. Facility policy titled Dressings, Dry/Clean, revision date of February 2014, documented the following: The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Under steps in procedure: Clean bedside table. Establish a clean field. Place clean equipment on the clean field. Wash and dry your hands thoroughly. Put on clean gloves and remove soiled dressing. Remove gloves and wash and dry your hands thoroughly. Put on clean gloves. Cleanse wound and apply clean dressing. Remove gloves and wash your hands thoroughly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Handwashing/Hand Hygiene, revision date of August 2015, documented the following: This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Use an alcohol-based hand rub or soap and water . before preparing or handling medications, before handling clean or soiled dressings, After handling used dressings or contaminated equipment, before and after entering isolation precaution settings. The use of gloves does not replace hand washing/hand hygiene. 49907 2. R28's admission record documents an admitted [DATE] with the following diagnoses in part; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and Neuromuscular dysfunction of the bladder. R28's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 08, indicating R28 is moderately cognitively impaired. Section H-bladder and bowel documents that R28 has an indwelling catheter. R28's current care plan documents that R28 is at risk for urinary tract infection (UTI) with a history of UTI with extended-spectrum beta-lactamase (ESBL). On 12/11/24 at 1:13pm, peritoneal care and catheter care was performed on R28 by V12 (CNA/Certified Nursing Assistant). V12 donned a gown for enhanced barrier precautions. V12 closed the door and pulled the curtain to provide privacy, she washed her hands and applied gloves. V12's supplies were already placed on the resident's bedside table with a clean barrier. V12 uncovered part of R28 and positioned legs, she then pulled the string for the light above R28's bed and then moved the biohazard container from one side of the bed to the other. V12 did not change gloves or perform hand hygiene prior providing peri care/catheter care. V12 Performed peritoneal care and catheter care on R28. No gloves changes or hand hygiene was observed throughout the course of the care. V12 completed care and removed soiled gloves. V12 did not perform hand hygiene and then applied a new pair of gloves to reposition R28. V12 did not clean bedside table after providing care. Facility policy titled Catheter Care, Urinary with a revision date of October 2010 was reviewed. In the section titled Steps in the procedure it documents in part that gloves should be removed, and hand hygiene performed before moving between internal and external areas of the genitalia. This document further states that the bedside table should be cleaned after providing care. 3. R8's admission record documents an admitted [DATE] with the following diagnoses in part; generalized muscle weakness and cognitive communication deficit. R8's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 09, indicating R8 is moderately cognitively impaired. R8's Order Summary Report documents an active order to Cleanse area to scrotum with soap and water pat dry, apply skin protectant with cooling menthol to area q (once a shift) shift, every shift for excoriation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24 at 1:36pm, V13 (Licensed Practical Nurse/LPN) was observed administering a treatment to R8 and was assisted by V12 (CNA). V13 had supplies set up on R8's bed side table with a clean barrier in place. V13 and V12 both washed their hands and applied gloves. V12 assisted in positioning R18, V13 began cleansing R8's scrotum with a clean washcloth with soap and water. V13 noted that R8 had a bowel movement but continued to clean R8's scrotum only. V13 then removed her soiled gloves, did not perform hand hygiene before applying new gloves. V13 applied skin protectant cream to area of excoriation. V13 removed soiled gloves, no hand hygiene was observed before applying new gloves. V13 then began cleaning resident's buttocks where bowel movement was. V13 then changed gloves, repositioned resident with V12's assistance and then cleaned up her workspace. 48356 4. R16's admission record dated 12/11/24 documents an admitted [DATE] with a diagnosis of hemiplegia and hemiparesis, gastrostomy status, dysphagia, and heart failure. R16's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental status (BIMS) score of 03 which indicates that R16 has severely impaired cognition. Section GG documents that R16 is dependent with toileting, eating, and transfers. R16's Care Plan with a revision date of 11/08/24 documents under focus: Potential for alteration in nutrition r/t (related to) requires tube feeding, dehydration risk, GERD (Gastroesophageal reflux disease), dyslipidemia, dysphagia, NPO (Nothing by mouth), Enhanced Barrier Precautions with a date initiated 09/05/24. Another focus area is potential for alteration in skin integrity r/t decreased mobility, fragile skin, gastrostomy site, edema, skin lesion, split behind ear, incontinence, re-occurring rash to neck fold, end of life process with comfort care measures. On 12/11/24 at 1:15PM, V9 (Registered Nurse) walked into R16's room which had enhanced barrier precaution signage on door along with PPE (Personal Protective Equipment) hanging on door which was easily accessible to staff. V9 had used hand sanitizer prior to walking into room. V9 did place gloves on prior to cleaning area around g-tube (gastrostomy) and then did hand hygiene prior to doing treatment to g-tube. V9 never donned a gown before or during care. 5. R41's admission record dated 12/12/24 documents an admitted [DATE] with a diagnoses of pressure ulcer of sacral region stage III, pressure ulcer of left buttock stage II and personal history of other diseases of the respiratory system. R41's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental status (BIMS) score of 13 which indicates that R41 is cognitively intact. Section GG documents that R41 is dependent with toileting. R41 requires set-up and clean up assistance with personal hygiene. R65 requires partial/moderate assistance with transfers. R41's Care Plan with a revision date of 10/17/24 documents under focus Potential for/actual alteration in skin integrity decreased mobility, edema, wound, incontinence enhanced Barrier Precautions 05/23/24 stage III coccyx, 05/23/24 SDTI (Suspected deep tissue injury) to right buttock, stage II. R41's interventions for this focus include enhanced barrier precautions with a date initiated 09/16/24. (continued on next page)

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	12/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 2:11PM, V9 and V3 (Assistant Director of Nursing/ADON) went into R41's room to perform a treatment on R41's. There was enhanced barrier precaution signage on door along with PPE (Personal Protective Equipment) which was easily accessible to staff. V9 (Registered Nurse) was observed providing wound care to R41 assisted by V3. R41's wounds were located to the coccyx and right buttock. V9 and V3 performed hand hygiene prior to treatment. R41's old dressing was removed by V3 and both wounds were cleansed by V3 who only had gloves on at the time care was performed. V3 never donned a gown before cleaning R41's coccyx and right buttock. V9 performed hand hygiene then donned new gloves, but never donned a gown while applying the new treatment to R41. On 12/12/24 at 10:44AM, V3 (ADON) stated that she should of donned a gown and gloves when she removed and cleaned R41's wound. V3 stated that she doesn't know why she didn't do it, she said that the enhanced barrier precautions is so new and she just forgets what all they are suppose to do. 6. R65's admission record documents an admitted [DATE] with a diagnosis of acute infarction of intestine, perforation of esophagus, and encounter for surgical aftercare following surgery on the digestive tract, R65's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental status (BIMS) score of 15 which indicates that R65 is cognitively intact. Section GG documents that R65 is dependent with toileting. R65 requires substantial/Maximal assistance with transfers. R65's Care Plan with a revision date of 07/11/2024 documents under focus R65 requires tube feeding r/t (related to) cervical esophagostomy G-tube (gastrostomy tube) for drainage, J-tube (Jejunostomy tube) for feeding proximal gastrectomy and reduction of abdominal content form chest surgical incision neck ostomy with ostomy bag for drainage interventions include in part Enhanced Barrier Precautions initiated on 09/05/2024. On 12/11/24 at 12:42PM, V9 (Registered Nurse) walked into R65's room which had enhanced barrier precaution signage on door along with PPE (Personal Protective Equipment) hanging on door which was easily accessible to staff. V9 washed her hands while in the room. V9 applied gloves and cleaned area around J-tube and G-tube. V9 then changed gloved and performed hand hygiene and placed a new pair of gloves on and then performed treatment to J-tube and G-tube. V9 never donned a gown during cleaning or when performing treatment to J-tube or G-tube. On 12/12/24 at 9:45AM, R65 stated when nursing staff comes in to do her treatments they don't wear a gown they only wear gloves when performing her treatment to J-tube and G-tube. On 12/11/24 at 3:20PM, V10 (Infection Preventionist) stated that any staff that does treatments or direct care activities to a resident that is on a enhanced barrier precautions should always don a gown and gloves before providing care. V10 said that staff should especially don gloves and gowns with working on open wound areas such as g-tube and j-tube. V10 said they do education on the enhance barrier precautions for all staff. V10 did not know that last time they had training on enhanced barrier precautions, but she does know that staff has had training on the enhanced barrier precautions. (continued on next page)

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	12/12/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 3:26PM, V9 stated she does not know if she is supposed to wear a gown or not when doing treatments on resident who are on enhanced barrier precautions. V9 stated that she knows that staff that are caring for the resident who provide direct care such as the certified nurse assistants should wear a gown and gloves on any resident that is on enhanced barrier precautions, but she doesn't think that she had to when doing treatment. V9 said that she might be wrong and she might need to be wearing a gown, but she hasn't been. V9 said that she does remember getting some training on enhanced barrier precautions but can't remember what all she was suppose to do. On 12/12/24 at 1:35PM, V2 (Director of Nursing/DON) stated that V9 and V3 should have donned gloves and a gown while performing treatments on R16, R41, and R65 along with all resident who are on enhanced barrier precautions. V2 said that staff was just educated on the enhanced barrier precautions, but that they are still confused on what all they need to have on while providing care to a resident that is on a enhanced barrier precautions. V2 said they will be doing more education on the EBP. The facilities policy titled Enhanced Barrier Precautions with a revision date of August 2022, documents under policy statement Enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant organism (MDRO's) to residents. The policy interpretation and implementation documents in part under 2. EBP (enhanced barrier precautions) employ targeted gown and gloves use during high contact resident care activities when contact precautions do not otherwise apply. A. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Section 3 documents in part Examples of high contact resident care activities requiring the use of gown and gloves for EBP's Include H. wound care (any skin opening requiring a dressing).