

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Fireside House of Centralia		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure that the food storage area was kept clean and swept and failed to ensure that policies and procedures were followed to prevent cross contamination. This failure has the potential to affect all 60 residents who reside in the facility. The Findings Include: On 02/17/2026 at 9:23 AM during the initial tour of the kitchen, the following items were observed: Dry storage room floor was littered with hair restraints, food crumbs, and spilled cereal. The lid on the cereal storage container for the corn flakes was broken not allowing it to have an air tight seal and potential for pests to enter and become stale. A handled scoop was found in the bulk flour bin. The ice machine interior flap had a pink substance found on it indicating that it needed sanitized. The brown sugar bowl on the serving steam table was open with a spoon in it and no staff present. On 2/17/26 at 11:00 AM, V4 (Cook) was observed preparing the pureed and mechanical soft food items. During this time, V4 opened the oven door, opened a drawer for utensils, assembled the blender to modify the food and then used the same gloved hands to put the meatloaf in the blender. As V4 was using a spatula to cut the meatloaf pieces, he would then use his gloved hand that had touched multiple surfaces to dump the portions of food into the blender. On 2/17/26 at 10:15 AM, V3 (Dietary Manager) stated that they had not had a chance to sweep the dry storage room and she would have that done along with removing the scoop from the flour and replacing the cereal bin lid. At this time, V3 also stated that V4 should not touch foods with his gloved hands, especially after touching other surfaces. A Handwashing and Glove use policy, with a revision date of 4/15/20, documents that: Guidelines for handwashing and glove use to promote safe and sanitary conditions throughout the Food and Nutrition Services Department must be followed. Gloves: 1. Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready to eat food. 2. When gloves are used, handwashing must occur per above procedure prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed, see above. Gloves may be used for one task only. 3. It is important to remember that gloves can often give a false sense of security and can carry germs the same as our hands. The Long-Term Care Facility Application for Medicare and Medicaid dated 2/17/26, documents that 60 residents reside in the facility.		

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 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. Based on observation, interview and record review the facility failed to ensure resident diet orders were provided as ordered for 4 of 4 (R8, R22, R23, and R26) residents reviewed for diet order accuracy in a sample of 44. The Findings Include: R8's admission Profile documents an admission date of 7/30/24. This same document includes the following diagnoses: dementia, type 2 diabetes, and dysphagia. The Order Listing Report documents that R8's diet order is easy to chew texture and regular/thin liquids. R22's admission Profile documents an admission date of 10/7/25. This same document includes the following diagnoses: Type 2 diabetes, depression and hypertension. The Order Listing Report documents R22's diet order is regular diet, regular/thin liquids and double protein with all meals, no double entr&eacute;e. R23's admission Profile documents an admission date of 5/23/24. This same document includes the following diagnoses: parkinsonism, pressure of the sacral region, and hypertension. The Order Listing Report documents R23's diet order as: Regular diet, regular/thin liquids, hand cut meat and double protein at meals. R26's admission Record documented an admission date of 1/15/26 with diagnoses including major depressive disorder, need for assistance with personal care, muscle weakness, abnormalities of gait and mobility, lack of coordination. R26's 1/21/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R26 was cognitively intact. R26's Order Summary Report printed 2/20/26 documented a 11/4/25 order for regular diet, regular texture, regular/ thin liquids consistency, double protein at meals no double entr&eacute;e. On 2/17/26 during the lunch meal service at 12:30PM, R8 was observed to have a small amount of protein on his lunch plate. At this time, V6 (Assistant Dietary Manager) stated that was all the mechanical soft meat that she had left and he is not a big eater, so she just gave him what she had. On 2/17/26 at 3:00 PM, V4 (Dietary Manager) stated that there was meatloaf left that could have been ground up to make more mechanical soft meat and that is what should have been done. V4 stated that the staff know if they run out of mechanically altered foods, they know to ask for more to be made. On 2/18/26 during the lunch meal service at 12:00 PM, it was observed that R22, R23 and R26 did not get the double protein portions served to them on their plate. On 2/18/26 at 12:10 PM, R23 who is alert to person, place and time stated that she only gets one serving of the meat option at the meal. R23 stated that she only had one slice of meatloaf on 2/17/26 and only has the one corndog on 2/18/26. On 2/18/26 at 12:15 PM, R22 who is alert to person, place and time stated that he only had the one corndog but would like another. On 2/18/26 at 1:45PM, V3 (Dietary Manager) stated that the staff serving the trays and staff delivering trays should check the tickets prior to delivering to the resident. V3 went on to state that they are trying to change those diet orders to be an extra ounce of protein rather than double. (continued on next page)		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/2026 12:35pm, V5 (Cook) stated that double protein means that residents should have received 6 tenders instead of 3 or the alternate corn dog should have gotten 2 instead of one. On 2/18/2026 12:36 PM, V6 (Assistant Dietary Manager) stated when residents have an order for double protein the staff on tray line should be adding double amounts of the protein option. On 2/17/26 at 11:42 AM, R26's noon time meal tray was delivered and contained one regular portion of meat loaf, mashed potatoes with gravy, corn, pie, tea, water, and juice. On 2/19/26 at 12:01 PM, R26's noon time meal tray contained a bowl of ham and potatoes, breadstick, an apple turnover, tea, water, and apple juice. R26 said she never got a meal tray with double protein portions or a meal with a peanut butter sandwich. On 2/19/26 at 1:04 PM, V3 (Dietary Manager) said residents with an order for double protein should receive 1 extra ounce of protein with meals. V3 said the new dietitian started recommending double protein for residents and the facility had made an addendum to the policy for double protein orders. V3 said on 2/19/26 at the noontime meal the residents with double protein orders should have received the regular entr&eacute;e and half of a peanut butter sandwich. On 2/19/26 at 1:41 PM, V10 (Registered Dietitian) said when a resident has an order for double protein, she would expect the facility to give 2 portions of the meal's protein to the resident. V10 said if the protein of the entr&eacute;e was a mixed dish she would expect the facility to give the regular portion to the resident and supplement with something like an ounce of peanut butter or some other form of protein. R26's Registered Dietitian progress note dated 2/9/26 documented in part . Res (resident) with 5% Wt (weight) loss/ 1mo (month) per HT (height): 69 2/9 WT: 310# (pounds/lbs) BMI (Body Mass Index): 46 Class III obesity. Jan WT: 325# (January weight 325 pounds). WT fluctuating R/T (related to) Dx (diagnosis): CHF (Congestive Heart Failure)/ Lasix use/ edema/ on daily WT's. Continue Reg (regular), double protein portions/ meals, no double entr&eacute;e. The facility's 1/26/26 Addendum to policy for Therapeutic Diets documented in part . 12. Those residents that have physician order for double protein will have extra protein added to designated meal through addition of 1 ounce of protein rich food added to meal.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review the facility failed to maintain the desirable water temperature in the facility shower for 1 (R26) of 5 residents reviewed for environment in a sample of 44. Findings include: R26's admission Record documented an admission date of 1/15/26 with diagnoses including major depressive disorder, need for assistance with personal care, muscle weakness, abnormalities of gait and mobility, lack of coordination. R26's 1/21/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R26 was cognitively intact. On 2/17/26 at 2:08 PM, R26 said the facility shower's water temperature did not get hot enough for her liking. On 2/18/26 at 1:53 PM, a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit (F). On 2/18/26 at 2:50 PM, the west hall's shower room's shower water temperature was 90.6 degrees F and the sink's water temperature was 94.8 degrees F. On 2/18/26 at 3:06 PM, V8 (Maintenance Director) said the resident's hot water heater was set at 117 degrees F that went to a mixing valve that was set at 106 degrees F. V8 said the mixing valve did not have a gauge to determine what it was set at. V8 said when the plumbing company had to replace the mixing valve, they determined what water temperature it was set at by taking the temperature of the water in the resident shower room. V8 said the water then went to a holding tank that did not have a heating element before going to a recirculation pump to the resident shower room and resident rooms. V8 said there was no way to know what the temperature of the water was in the holding tank. V8 said he thought the recirculation pumps were working. V8 said he tested the water temperatures in resident rooms and shower rooms weekly. On 2/18/26 at 2:58 PM, V9 (Certified Nursing Assistant/ CNA) said she would turn the hot water on in the shower and let it run for 5 to 10 minutes prior to assisting a resident to shower so the water would be warm enough. V9 turned on the shower and left it running. On 2/18/26 at 3:06 PM, the west hall's shower room's water temperature measured 97.8 degrees F and did not feel warm enough to shower in. The facility's water temperature logs from 10/27/25 through 2/16/26 documented all resident rooms and shower rooms water temperatures measured 106 degrees F. The facility's 2/19/26 plumbing company's receipt documented in part . Replaced recirc (recirculation) pump for west wing. Was only getting 98 (degrees) water now getting 104 (degrees). The facility's revised 2009 'Water Temperatures, Safety policy documented in part .1. Water heaters that service resident rooms, bathrooms, common areas, and tub/ shower areas shall be set to temperatures on no more than 110 (degrees F) . or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review the facility failed to ensure that significant change assessments were completed timely for 1 of 1 (R63) residents reviewed for significant changes in a sample of 44. The Findings Include: R63's admission Profile sheet documents an admission date of 7/2/2022. This same document includes the following diagnoses: Hemiplegia and Hemiparesis, Type 3 Diabetes and Dysphagia. R63's current physician order sheet shows that Hospice was started on 10/29/2025. R63 did not have a significant change Minimum Data Set Assessment completed at this time. A Minimum Data Set submission report documents that R63's target date for her significant change assessment was 11/4/2025 and was submitted on 2/16/2026. There is a message documenting that the assessment completed late: is more than 14 days after assessment reference date. On 2/19/26 at 2:00 PM, V2 (Director of Nursing) stated that she did not complete the significant change assessment for R63 at the time of the Hospice order. V2 stated that she will get started on submitting this.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on interview and record review the facility failed to timely submit quarterly assessments for 1 of 1 (R45) residents reviewed for timely submission of assessments in a sample of 44. The Findings Include: R45's admission Record documents an admission date of 7/11/2024. This same document includes the following diagnoses: heart failure, anxiety disorder and chronic kidney disease. R45's quarterly Minimum Data Set (MDS) Assessment with a target due date of 1/13/2026 did not document that it was transmitted. A Final Validation Report documents that R45's MDS with a target date of 1/13/2026 was submitted on 2/19/2026 with a warning that the assessment was completed late due to being more than 14 days after the assessment reference date. On 2/19/2026 at 2:00 PM, V2 (Director of Nursing) stated that MDS was in progress and not completed and would work on getting that completed today and submitted.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review the facility failed to timely submit discharge assessments for 1 of 1 (R36) residents reviewed for discharge assessments in a sample of 44. The Findings Include: R36's admission Record documents an admission of 9/2/25. The same document includes the following diagnoses: Type 2 Diabetes, Hypertension, Cognitive Communication Deficit, and anemia. R36's discharge Minimum Data Set (MDS) Assessment documented it was completed but not submitted on 9/30/2025. A Final Validation Report documents that R36's discharge MDS with a target date of 9/30/2025 was transmitted on 2/19/2026 with the warning error: Record submitted late, the submission date is more than 14 days after the assessment reference date. On 2/19/2026 at 2:00 PM, V2 (Director of Nursing) confirmed that R36's discharge assessment had not been transmitted.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, record review and interview the facility failed to provide assistive devices at meals as ordered for 3 of 3 residents (R3, R25 and R55) in a sample of 44 reviewed for assistive devices at meals. The Findings Include:R3's admission Profile documents an admission date of 11/24/25. This same document includes the following diagnoses: Type 2 Diabetes Mellitus, unspecified lack of coordination, and major depressive disorder. R3's diet listed on the Facility Order Listing Report is as follows: Regular texture, regular/thin liquids, 8 ounces of extra fluids and built-up silverware to assist while eating.R25's admission Profile documents an admission date of 8/6/25. This same document includes the following diagnoses: Major Depressive Disorder, Anxiety Disorder, and Alzheimer's Disease. R25's diet listed on the Facility Order Listing Report is as follows: easy to chew texture, regular/thin liquids and build up silverware and divided plate with all meals.R55's admission Profile documents an admission date of 8/14/25. This same document includes the following diagnoses: Major Depressive Disorder, Dementia and hypertension. R55's diet listed on the Facility Order Listing Report is as follows: Regular texture, regular/thin liquids, weighted utensils and whole milk and juice with all meals. On 2/17/2026 at 12:00 PM, R3, R25 and R55 were observed during lunch mealtime to not have special silverware. R3, R25 and R55 all had regular silverware.On 2/18/26 at 12:15 PM, R3, R25 and R55 were observed to be provided the same regular silverware as the rest of the residents in the dining room.On 2/18/26 at 1:45PM, V3 (Dietary Manager) stated that the staff serving the trays and delivering the trays should check the tickets prior to delivery. On 2/18/2026 at 12:36 PM, V6 (Assistant Dietary Manager) stated when residents are ordered adaptive utensils, dietary staff are to read the card and put them on the tray during tray line.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precaution (EBP) infection control precautions for 1 of 6 residents (R11) residents reviewed for infection control in the sample of 44. The findings include: R11's admission Record documented an admission Date of 8/4/25 and listed Diagnoses including Diabetes Type 2, Chronic Obstructive Pulmonary Disease, Hypertension, and Gastrostomy Status. R11's Minimum Data Set, dated [DATE] documented that R11 was receiving enteral feeding. R11's Care Plan dated 1/29/26 documented a problem area, (R11) On EBP due to gastrostomy tube. On 02/18/2026 at 10:50am, V7 (Licensed Practical Nurse) was observed administering G (Gastrostomy) Tube medications to R11. A sign on R11's door read: (EBP) Enhanced Barrier Precautions. Hanging on the door were PPE (Personal Protective Equipment) supplies including gowns, gloves, and N95 masks. After handwashing, V7 donned gloves, but no gown, and entered the room. Following the procedure, the Surveyor asked V7 about the EBP sign and what it meant. V7 stated R11 had no infection in the gastrostomy and was not on isolation. The Surveyor asked V7 what PPE should be donned for EBP, and V7 stated she was not normally working on this hall, and this was only her second time working on this hall, and forgot R11 was on EBP, and stated there were no gowns available, but gowns were observed in the PPE supplies on the door. On 02/20/2026 at 8:07am, V2 (Director of Nurses) stated the PPE to be donned for EBP is gown and gloves. An Enhanced Barrier Precautions Policy dated 2001 documented, 2. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high contact resident care activities requiring the use of gown and gloves for EBP's include: G. Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review the facility failed to maintain a functioning call light system for 2 (R15 and R54) of 5 residents reviewed for environment in a sample of 44. Findings include: 1. R15's admission Record documented an admission date of 3/3/25 with diagnoses including pneumonia, sepsis, and anemia. R15's 12/25/25 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, indicating R15 was moderately cognitively impaired. On 2/17/26 at 11:11 AM, R15 and R54's room was observed to have a call light box on the wall with capped off wires with no cord call lights present. R15 was resting in bed with his eyes closed with an analog call bell sitting on his bedside table. On 2/17/26 at 1:57 PM, R15 was very hard of hearing and did not answer some questions appropriately. R15 was asked if he had a call light and R15 said no. R15 was asked what the analog call bell sitting on his bedside table was for and R15 said it was his bell, but he didn't really use it. R15's analog call bell was rung once, and staff did come to R15's room. On 2/20/26 at 11:43 AM, V1 (Administrator) said R15 could have a pendent call light if R15 wanted but wanted to keep the analog call bell. 2. R54's admission Record documented an admission date of 12/18/25 with diagnoses including fracture of neck of right femur, presence of right artificial hip joint, Alzheimer's disease, seizures, and need for assistance with personal care. R54's 12/24/25 MDS documented a BIMS score of 5, indicating R54 was severely cognitively impaired. On 2/17/26 at 1:51 PM, R54 was slightly confused during this interview and was alert to person. R54 said he did not have a call light. R54 was asked how he alerted staff if he needed something and R54 said staff would just come in and check on me, so it's OK. On 2/20/26 at 11:43 AM, V1 was asked what R54 used as a call light and V1 said R54 had a pendent call light that hung from a lanyard that rang to a box at the nurse's station. On 2/20/26 at 11:50 AM, R54 was sitting in his wheelchair in his room and was alert to person and place at the time of this interview. R54 was asked if he had a call light and R54 responded no. R54 was asked if he had a call light that hung from a lanyard that he could wear and R54 answered yes. R54 was asked where his pendent call light was and R54 said he thought it was on his bedside table, but it was not able to be found. R54 was asked if he was wearing it and R54 answered no. R54 said he was not sure where his pendent call light could be. On 2/20/26 at 11:32 AM, V13 (Certified Nursing Assistant/ CNA) said she had never heard R15 use his analog call bell and was not sure if R15 was aware of what the analog call bell was for. V13 said on 2/17/26 when R15's analog call bell was tested was the first time V13 had heard it. V13 said she was not sure if R54 had a call light or not. On 2/20/26 at 11:28 AM, V12 (CNA) said she usually worked nightshift. V12 said during the night R15 and R54 were checked on at least every 2 hours to see if they needed anything. V12 said she had never heard R15 use his analog call bell. V12 said during the day R54 is usually up in his wheelchair and if he needed something he would come out into the hallway to get staff's attention. V12 said she did not think R54 had a call light, but staff were always on the hall if he needed something. On 2/18/26 at 2:09 PM, V8 (Maintenance Director) said R15 and R54's call light system could not be fixed. V8 said due to the system being so old parts to fix it could not be obtained. V8 said the facility had an outside electrical company come to the facility but they were also unable to obtain parts to fix the call light system. On 2/20/26 at 11:28 AM, V1 (Administrator) said the facility did not have a call light policy.		