STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145666	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centralia Manor	1910 East McCord Rte 161 East 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview, observation, and record review the facility failed to implement effective and progressive interventions to prevent falls for 2 out of 3 residents (R1 and R2) reviewed for fall prevention in the sample of 8. Findings include: 1. R1's document titled Residents Face Sheet documents an admitted [DATE] including diagnoses of Fracture of left hip, Fracture of right clavicle, Alzheimer disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Anxiety disorder, Chronic Respiratory Failure, Hypertension. R1's MDS (Minimum Data Set) dated 8/14/2024 includes a BIMS (Brief Interview for Mental Status) score of 3 indicating severe cognition impairment. Section GG includes R1 is dependent for toileting, shower, lower body dressing, putting on/taking off footwear. R1 requires substantial/maximal assist with sit to lying, lying to sitting on side of bed and rolling left to right. R1 is dependent for sit to stand, and chair/bed to chair transfer. R1 walks 10 feet with supervision or touching assistance. Walks 50 feet with two turns documents not applicable. R1 walks 150 feet documents resident refused. Section H documents R1 is always incontinent of bowel and bladder. R1's Care Plan documents R1 is at risk for falling related to decreased mobility, muscle weakness, arthritis, and Alzheimer's Disease. R1 is impulsive and attempts to stand at times. Short term goal dated 11/22/2024 is R3 will have minimal risk for injury related falls. Approaches: activities as tolerated dated 10/15/2024, offer busy box as tolerated 10/6/2024, place in activities or nurses station as tolerated when awake 9/5/2024, alternate call light, touch pad call light dated 8/16/2024, sent to emergency room for evaluation dated 7/25/2024, attempt to lay R1 down when sleepy as tolerated 7/24/2024, assist R1 with activities of interest after meals dated 7/22/2024, encourage R1 to use side rails and hand rails as needed dated 6/8/2024, Instruct R1 to call for assist before getting out of bed or transferring. Encourage R1 to stand slowly, provide R1 with specialized wheelchair dated 6/8/2024, and Therapy to evaluate and treat as ordered dated 6/8/2024. R1's Event Report dated 7/23/2024, observed fall in the day room and no injury noted. Notes dated 7/24/2024 at 10:05AM, IDT (Interdisciplinary Team) met to discuss witnessed slide out of wheelchair to floor. Approach: staff to offer R1 to lay down when tired. (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 - Minimal harm or potential for actual harm Residents Affected - Few	R1's Event Report dated 7/25/2024 at 10:31AM documents R1 had a fall near nurse's station. Fall was unwitnessed with an injury. Knot forming to right side of head, skin tear right pinky knuckle. Notes dated 7/26/2024 at 10:14 AM, IDT met and discussed fall from 7/25/2024. R1 got up from wheelchair and fell forward hitting right side of head on floor. R1 had just been toileted. R1 sent out to rule out concussion. R1 sent back clear but does have a diagnosis of UTI (Urinary Tract Infection). Resident is impulsive and attempts to transfer self at times. Will place R1 in activities as tolerated while awake. R1's Event Report dated 8/15/2024 at 10:21 PM documents R1 had an unwitnessed fall in day room. Notes dated 8/16/2024 at 10:04 AM, documents IDT met and discussed fall from 8/15/2024. R1 observed next to wheelchair back against wall. R1 on isolations for COVID and staying in room. R1 has cognitive impairment and unable to make her needs known. R1 usually stays at nurses' station for staff to monitor as she is high risk for falls. R1 placed on alternate call light and placed a touch pad call light. R1's Event Report dated 9/5/2024 at 3:55PM, documents R1 had unwitnessed fall at nurses' station, R1 rated pain at a 5 on a scale of 0-10 to right shoulder/wrist with bruising, redness, and swelling noted. Notes dated 9/6/2024 at 10:10AM, documents IDT met and discussed resident being observed in the floor. R1 has Alzheimer's and unable to say what she was doing. R1 is impulsive at times and often to transfer self. Staff will ask to resume PRN (as needed) anxiety med and offer activities as tolerated. R1's Resident Progress Notes dated 10/6/2024 at 10:00AM R1 found lying on the floor at front office asleep. Wheelchair at side with glasses folded by head. Floor clean, dry, and free of clutter. R1 fully dressed with well-fitting shoes on. Two 2x3 cm (Centimeter) skin tear noted on right elbow. Cleansed, steri-strips applied. Assisted back to wheelchair and laid down in bed to rest. Neuros started. On 10/9/2024 IDT met and discussed fall from 10/6/2024. R1 appeared to lay down in floor by front office. R1 had taken her eyeglasses off and laid them down. Will offer busy box, newspaper and coloring sheets as tolerated. R1's Resident Progress Notes dated 10/10/2024 at 3:30PM, CNA's (Certified Nursing Assistants) called nurse over to 400 Hall. Observed R1 sitting on bottom, on floor of another resident's room, R1 was sitting between the beds. Wheelchair to right side of R1. R1 not sure of why she fell , CNA's stated R1 wandered and often goes to different rooms/halls and tries to stand without assist. ROM (Range of Motion) within normal limits x4, moves all extremities without pain/discomfort. No red or open areas noted, R1 assisted back to wheelchair and started neuros due to unwitnessed fall. Documentation on 10/15/2024 at 10:48AM IDT met this AM and discussed resident being observed in the floor on 10/10/2024. R1 is impulsive a times and does wander throughout facility. R1 was unable to state what she was doing. Staff encouraged activities of interest after meals. On 10/22/2024 at 1:03 PM, V5 (Certified Nurse Assistant/CNA) stated R1 wanders all over the facility in her wheelchair. V5 stated R1 has had several falls and the staff try to keep her busy by close monitoring and taking her to activities. V5 stated most of R1's falls are from her wheelchair, and possibly one from her bed. V5 stated she has never witnessed a fall that R1 had but she has heard of the falls. V5 stated we are a no alarm facility so unless we see her trying to stand up and unless we are right there with her, we don't always see her. V5 stated she was not sure on all of R1's interventions for fall prevention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/2024 at 1:15PM, V6 (CNA) V6 stated R1 wanders all over the facility in her wheelchair and she does have frequent falls, but she propels herself all over the place. V6 stated she was unsure of fall interventions for fall prevention but thought one was to keep R1 at the nurses station or activities department for close monitoring. On 10/22/2024 at 1:22PM, V7 (CNA) stated R1 was always wandering around in her wheelchair but we tried to keep her close to us. V7 stated R1 was very hard of hearing and had hearing aids but would take them out all the time. V7 stated R1 had several falls especially from her wheelchair. V7 was asked if she knew the interventions or fall preventions for R1 and she stated, No not really but I know we tried to keep her close and take her to activities. We tried to keep her occupied. V7 stated R1 could not stand up because she was bent at the knees. V7 stated she didn't know why. V7 was asked if R1 was on a restorative program and V7 stated I am not sure and, but she may be on a walking program. V7 stated she does not walk her though. On 10/22/2024 at 1:50 PM, V8 (CNA) was asked if she knew R1's fall interventions and she stated, Not really sure, but I know we try to keep her busy. V8 stated we do not have alarms, so we try to keep her occupied by taking her to activities. V8 stated R1 has hearing aids but she would take them off all the time. On 10/24/2024 at 11:34 AM, V18 (Activity Director) stated typically on Mondays-Fridays R1 is brought down to activities to try to keep her within sight of staff and to keep her occupied with activities of interest. V18 stated R1 wanders throughout the facility all the time and has falls at times when she tries to stand up out of wheelchair. V18 states the activity department tries to keep her busy throughout the day. V18 stated the nursing staff always come to check her and take her to the bathroom about every 2 hours. V18 stated sometimes the staff will put her in the recliner at the nurse's station to give her a rest from the wheelchair but she doesn't want to stay there long. V18 stated the staff always try to lay her down if she gets tired and she doesn't stay there long either. V18 stated he would get aggravated somedays when the nursing staff would not bring her down to activities and just let her wander so he would try to bring her down to activities every time he saw her. V18 stated R1 is very confused and very hard of hearing. V18 stated R1 has hearing aids but she will not leave them in. V18 stated many days R1 cries for her Dad and Mom and wants to go look for them. V18 stated she is not easily redirected at times. V18 stated there are many activities specific for R1 and somedays she doesn't want anything to do with any of it. V18 stated R1's care is good, and we all work together to try to keep R1 safe. V18 stated the facility bought a busy blanket for R1 but it didn't really help much. V18 stated some days she likes to clean off the tables with a cloth, so we wet a rag and let her clean the tables. 2. R2's Resident Face Sheet documented an admitted [DATE] and includes diagnoses of Sepsis, Chronic Atrial Fibrillation, Endocarditis, Hypoglycemia, Acute Kidney Failure. MDS dated [DATE] includes a BIMS (Brief Interview of Mental Status) score of 9 suggests moderate cognitive impairment. Section GG documents R2 has impairment on both sides to lower extremities. R2 requires set up for eating, partial to moderate assistance with oral hygiene, toileting, shower/bathing, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene, rolling left and right, sit to lying, sit to stand, chair to bed and bed to chair transfers, toilet transfer. Walking is documented as no applicable. Documents R2 uses a manual wheelchair for mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's current Care Plan documents R2 is at risk for falling related to decreased mobility, DM (Diabetes Mellitus), and atrial fibrillation. R2 is impulsive and doesn't always use call light. Goal is, R2 will have minimal risk for injury related to falls. Approach's documents include Anti roll backs 8/19/2024, Obtain UA (Urinalysis) 8/13/2024, therapy to evaluate chair 7/25/2024, bowel and bladder tracking 7/24/2024, obtain UA 7/15/2024, continue therapy 7/13/2024, fall mats 6/14/2024, touch pad call light 6/14/2024, low bed 6/11/2024, urinal at bedside 6/10/2024, assist R2 with activities of interest 5/17/2024, encourage R2 to call for assistance before getting out of bed or transferring. Encourage R2 to stand slowly 5/17/2024 and provide R2 with specialized equipment: wheelchair and or walker. R2's Facility Event Summary Report reviewed for the last 3 months. The document included falls involving R2 on 10/18/2024, 10/16/2024,10/15/2024, 10/12/2024, 8/16/2024, 8/12/2024, 7/24/2024, and 7/23/2024. R2's Event Report dated 7/23/2024 at 10:00AM documents R2 was observed sitting in the floor against closed bathroom door and R2 stated wanted to use the bathroom. R2's Event Report dated 7/24/2024 documents no description of fall but documents IDT met to discuss fall from wheelchair in bathroom and approach for Therapy to inspect chair for proper fit. No injuries documented. R2's Event Report dated 8/12/2024 documents R2 had gotten up from the table and stated he had an errand to run. Family member present stated resident had started walking down the hallway and lost balance. Fall was witnessed. Will ask for UA as resident is often looking for the restroom. No injuries. R2's Event Report dated 8/16/2024 at 10:11AM, documents R2 sitting in floor of common area by nurses' station, stated he tried to get in his chair but missed. Chair was next to him but unlocked. No complaints of pain or discomfort and denied hitting head. IDT met this AM (8/16/2024 at 11:27AM) and discussed resident's fall. He was attempting to transfer self from a regular chair into wheelchair in which wheelchair brakes were not locked. Requested for anti-roll backs be placed on wheelchair. R2's Event Report dated 10/12/2024 at 12:21 PM, documents R2 was observed in the restroom. Had taken himself to the restroom. R2's IV medicine ball in bag was dragging on floor behind him. R2 was assisted back to bed. Physician was notified and ordered to send R2 to the emergency room to have IV checked for placement. No fall intervention documented for this fall. R2's Event Report 10/15/2024 at 2:36PM, documents event details document location of fall was in R2's room, unwitnessed, no pain, no injury noted, no other description of fall or interventions placed. R2's Event Report dated 10/16/2024 at 1:45PM, documents R2 was observed on rest room floor. Took himself to restroom. Bathroom well lit. Was fully dressed with front on pants wet, had nonskid socks on. Floor in bathroom dry and uncluttered. IV medicine ball in bag around neck. Offers no complaints of pain or discomfort. Assisted back to chair. No new fall interventions noted to report. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Event Report dated 10/18/2024 at 6:23PM, documents nurses heard noise in R2's room. Observed R2 on floor with back against bathroom door, knees bent and wheelchair facing towards R2. Observed laceration to tight 2nd digit of hand with moderate amount of bleeding, measures 1cm (Centimeter) length, 1cm wide, and 0.1cm depth. Area cleaned with wound cleanser and dry dressing applied. ROM (Range of Motion) x4, denies pain, discomfort when asked. R2 stated he was going to use bathroom when he slid out of wheelchair while trying to stand unassisted. Grip socks on and call light off. Mechanical lift used to transfer R2 to bed. Urinal offered and R2 stated he didn't need to use it. No new interventions noted on this document. On 10/23/2024 at 12:45 PM, R2 who was oriented to person, place and year lying in he bed stated he does have falls and usually because he tries to get up by himself. R2 stated he does require assistance to go to the bathroom. R2 stated he would like more candy, but the food is good, and he gets some kind of shake that he drinks sometimes for breakfast. R2 started getting confused as the conversation continued. R2 stated he didn't know where his call light was, and he didn't know how to use it. Call light noted beside R2's arm and was a pad call light with a big red cross on it. R2's was shown his call light and stated he didn't recognize it. R2 stated he was tired and started picking at picc line that was noted to be in his right upper arm. R2 stated he is here because he needed therapy and now, he is getting medication for an infection. R2 had regular socks on instead of anti-slip socks as fall intervention. R2 did not have fall mats in his room and urinal was out of reach, urinal noted sitting on nightstand across the room from his bed. R2' s bed was in a low position. On 10/23/2024 at 1:17PM, V13 (RN) stated R2 is unsteady on his feet. V13 stated R2 tries to help himself and he falls. V13 stated R2 has to urinate several times a day. V13 stated he is encouraged to use the call light for assistance, but he doesn't use his call light very often. V13 was asked what interventions were in place for R2 and V13 stated I know we are to encourage him to use the call light for assistance, but he doesn't even after encouragement. V13 did not know any other interventions. On 10/23/2024 at 1:00PM, V15 (CNA) stated R2 is supposed to have grippy socks on and is compliant with wearing those types of socks. V15 stated R2 gets up a lot and doesn't use his call light. V15 stated R2 will sometimes yell for help but not always. V15 entered room and observed the urinal was on the bedside table which was placed across the room from the bed. V15 validated the urinal was not within reach for R2 if R2 was in the bed. V15 was asked if she was aware of all the fall interventions in place for R2 and stated, I know he is supposed to use the call light and he is in a low bed. V15 was asked where the fall mats were, and V15 looked and stated, There is none in here and she hadn't seen any in this room. V15 stated R2 has frequent falls, and it is because he tries to transfer himself to go to the bathroom and he falls because he is unsteady on his feet. V15 states she normally always works the hall where R2 resides. On 10/23/2024 at 12:45PM, V3 (Assistant Director of Nursing) stated falls are reviewed every morning in meeting and interventions are put into place at that time. V3 stated they have no alarms in the facility. V3 stated the Nurses and CNAs get in serviced with every new intervention. V3 stated the facility does not have a Fall Policy at this time. V3 stated R2 is impulsive and tries to transfer himself causing falls. V3 stated R1 is impulsive as well and R1 wanders throughout the facility via wheelchair and tries to stand up causing falls. No in-service sheets for education for fall interventions were presented.