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 ______	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	**1030 MARTIN LUTHER KING BLVD CENTRALIA, IL 62801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 21 14. The arms of R6's reclining wheelchair was observed to be ripped and cracked at 12:15PM on 01/23/12. At the time of the observation R7 was observed to be wearing protective sleeves to the upper extremities. 15. The HCFA 672(Resident Census and Conditions of Residents) completed 1/23/12 indicated that there were 75 residents in the facility at the time of the survey. 16. The failure to maintain the floors, walls, and furnishings clean and in good repair were confirmed with E1 (Administrator) at 3:45 P.M. on 1/24/12.	F 465		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder.	F9999		

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 ______	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	1030 MARTIN LUTHER KING BLVD CENTRALIA, IL 62801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 22	F9999		

These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact

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 ______	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	**1030 MARTIN LUTHER KING BLVD** **CENTRALIA, IL 62801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 23 with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on record review and interview, the facility failed to immediately report the events of potential abuse to the administrator and failed to prevent further potential resident abuse during abuse investigations. This has the potential to affect all 75 residents who reside in the facility. The findings include: 1. Review of the facility's 3 resident abuse allegation investigations from the past year on 1/25/12, found that during 2 of the 3 investigations the employees accused of abuse were not immediately removed from duty. 2. On 1/25/12 an abuse investigation was reviewed from 4/7/11. The investigation summary indicated that on 4/7/11 at 4:30am, E6 (LPN Licensed Practical Nurse) observed E7 (Certified Nurse Aide, CNA) enter R16's room and overheard E7 to say to the resident "I'm not going to give you anymore water because you will piss the bed". The report continues by saying that E6 reported the incident to E8 (LPN) at shift change and that it was then reported to E4 (Registered Nurse, RN) by E8. The report states E7 was suspended after the notification of the events to E8. The Suspected / Actual Resident Abuse, Neglect or Mistreatment Notification	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	**1030 MARTIN LUTHER KING BLVD** **CENTRALIA, IL 62801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 24	F9999		

Checklist(undated) for this investigation indicates E8 was notified on 4/7/11 at 1030 am. E7 was allowed to complete the shift of work after the 4:30am incident. The checksheet indicates E1 (Administrator) was not notified of the events until 2:30pm on 4/7/11.

3. On 1/25/12 an abuse investigation was reviewed from 6/26/11. A written statement prepared by E9 (CNA) stated that at 9:45pm, E10 (CNA) stated to R23 "I am going to get your dentures if you like it or not." The written statement continues by stating that E10 spoke about forcing R23's jaw down to get R23's dentures out. A second written statement from E11(licensed Practical Nurse)written at 11:00pm on 6/26/11 finds that E9 reported the incident to E11. The Suspected / Actual Resident Abuse, Neglect or Mistreatment Notification Checklist for this investigation indicates that E11 did not report the events until 8:40 am on 6/27/11 and that E1 was not notified until 11:00am on 6/27/11. An undated Abuse Investigation report for R23 finds that E10 was not suspended until an unstated time on 6/27/11.

4. The lack of timely notification and resident protection during the R16 and R23 abuse investigations was confirmed on 1/25/12 at 4:30pm with E1. The census of 75 was obtained from the facility's 672 Resident Census and Condition of Residents completed on 1/23/12.

The findings include:

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 ______	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	1030 MARTIN LUTHER KING BLVD CENTRALIA, IL 62801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 25 1. Review of 2 of 3 resident abuse allegations for the past year on 1/25/12 found that the facility's policy "Abuse Program : Resident Protection " dated August 1999 was not followed. The Statement of Policy states "Any employee who is accused of resident abuse, whether physical, verbal or sexual, will be suspended pending further investigation." Under Procedure 5. "If abuse is suspected, the employee will immediately be sent home..". Review of 2 of 3 resident abuse allegations for the past year on 1/25/12 found that the facility's policy "Abuse Program: Investigation / Reporting / Response" dated August 1999 was not followed. Procedure: "1. Reporting: All employees are required to immediately notify the administrative or nursing supervisory staff that is on duty on an complaint of , observation of, or suspicion of resident abuse, mistreatment or neglect." 2. Investigation: "a The administrative or nursing supervisor assumes responsibility for: i. Immediate notification of the Director of Nursing and the Administrator (by phone if necessary);" 2. Review of an abuse investigation from 4/7/11 finds that E7 (CNA) was accused of abuse to R16 that was overheard by E6 (LPN) at 4:30am. The report indicates that E6 failed to immediately send the staff member home, per the facility policy. The report finds E7 was suspended via a phone call on 4/8/11 by the Director of Nursing (DON). The Suspected / Actual Resident Abuse, Neglect or Mistreatment Notification Checklist denotes that E1 (Administrator) was not notified	F9999		

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 ______	**01/30/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	**1030 MARTIN LUTHER KING BLVD** **CENTRALIA, IL 62801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 26 of the event until 2:30 pm on 4/7/11. 3. Review of an abuse investigation from 6/26/11 finds that E10 (CNA) was accused of abuse to R23 that was witnessed by E9 (CNA) and reported to E11 (LPN). The report indicates that E11 failed to immediately send E10 home, per the facility policy. The undated written investigation states E10 was suspended on 6/27/11. The report further stated the allegation was not reported to any administrative staff until 6/27/11 at 8:40 am and not to E1 until 11:00am on 6/27/11. 4. The lack of timely action and failure to follow the facility's policy's were discussed with E1 at 4:30pm on 1/25/12. The census of 75 was obtained from the facility's 672 Resident Census and Condition of Residents completed on 1/23/12. (B)	F9999		