Illinois Department of Public Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILAN	O CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMIL	LILD
		IL6012355	B. WING		07/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CENTRAL	IA MANOR	1910 EAST CENTRALIA	MCCORD RTI A, IL 62801	E 161 EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure and	d Certification				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations				
	300.610a) 300.1210b) 300.2040b)2) 300.2040d)					
	Section 300.610 Res	ident Care Policies				
	procedures governing facility. The written p be formulated by a Re Committee consisting administrator, the advimedical advisory comof nursing and other spolicies shall comply. The written policies stall the facility and shall be	of at least the visory physician or the simittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating se reviewed at least annually cumented by written, signed				
	b) The facility shall pr and services to attain practicable physical, i well-being of the resideach resident's comp	eneral Requirements for I Care ovide the necessary care or maintain the highest mental, and psychological dent, in accordance with rehensive resident care roperly supervised nursing				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE **Electronically Signed** 08/01/24 Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6012355	B. WING		07/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CENTRAL	IA MANOR		MCCORD RTI A, IL 62801	E 161 EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
\$9999	resident to meet the treat care needs of the resident and acceptance of the diestitian. 2) The diet shall be seed in the state of the dietitian. 2) The diet shall be seed in the shall be recorded in the shall be shall be recorded in the shall be recorded in the shall be shall be recorded in the shall be shall b	re shall be provided to each otal nursing and personal ident. et Orders rite a diet order, for each hether the resident is to herapeutic diet. The hay delegate writing a diet erved as ordered. be observed to determine st, and these observations he medical record. were not met as evidence observation, and record ed to provide prescribed ats and provide assistance tor intake for one of one red for weight loss in a failures resulted in R20 e and continuing weight loss ths. atted 07/11/24, documents the facility on 08/18/23 with chronic obstructive major depressive disorder, dementia, cognitive t, dietary calcium deficiency,	S9999			

Illinois Department of Public Health

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		IL6012355	B. WING		07	7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CENTRAL	IA MANOR		ST MCCORD RTE	I61 EAST		
	CHMMADV CT		ALIA, IL 62801	DROVIDER'S DI ANI OF A	CORRECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	e 2	S9999			
	documents under R2 interventions of pure breakfast, fortified punutritional supplemer care areas listed for a or weight loss in the R20's Physician ordedocuments diet pure (nutritional suppleme of 6/25/24. Prior diet	e diet with super cereal at adding at lunch/supper, and at at meals. There were no areas pertaining to nutrition care plan. ers dated 06/25/24 ed add house supplement ent) with meals with start date order dated 08/23/23				
	protein supplement.	iet with high calorie high				
	documents in Section mental status (BIMS) severely impaired co- document substantia eating. Section K doc	l/maximal assistance with cuments no weight loss or n the last month or 10% or				
	Electronic Medical Remeal percentages. La	ecuments found in R20's ecord document no recent ast meal percentage that s on 12/07/23 at lunch which 5% of her meal.				
	(pounds), 2/1/24- 98. 4/1/24- 93.4 lbs, 5/1/27/1/24- 84.2 lbs. Fro experienced an 8.48° within 3 months.	weights as 1/1/24- 95.8 lbs 2 lbs, 3/1/24- 94.8 lbs, 24- 92 lbs, 6/1/24- 90 lbs, m 5/1/24 - 7/1/24 R20 % or severe weight loss				
	R20's Dietitian Asses	ssment dated 7/5/24: On a				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION		E SURVEY PLETED
7.1.12 . 27.1.1	o. 001.11.2011011		A. BUILDING:			
		IL6012355	B. WING		07	7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
		1910 EA	ST MCCORD RTE	161 EAST		
CENTRAL	IA MANOR		LIA, IL 62801	10. 2.0.		
()(1) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	, 	PROVIDER'S PLAN OF CO	APPECTION .	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	e 3	S9999			
	Dureed diet with Hou	se Supplement at meals.				
		unch and supper. Super				
		ntakes 25-75%. Weights:				
		4, (6/28): 84, (6/21): 86.6,				
		(4/6): 92, and (1/7): 93.4.				
	, , , , ,	vn 3# (pounds) (4.4%) x/14				
		x/21 days, down 8# (9.0%)				
		10.0%) x/3 months, and				
	,	months. On daily weights.				
	Below IBW (ideal boo	dy weight) Range 105-134.				
	Body Mass Index: 14	.67 (underweight). Had 3+				
	Left LE edema and 2	+ Right LE edema, no				
	reports of edema nov	v, on Lasix. Potential risk for				
	weight changes and	•				
	_	ary offers 15+ servings/day.				
		E. No new labs to review. On				
		nent. Estimated Needs: 1330				
	`	ries per kg), 1330 cc fluids (1				
		and 38-46 gram protein				
		. Expect weight changes as				
	edema changes and Continue with diet Rx	• •				
	Continue with diet Rx	and monitor.				
	P20's Distition Asses	sment dated 6/12/24: On a				
		Calorie High Protein				
		Pudding at lunch and				
		I at breakfast and House				
		cream at meals. Intakes				
		11): 87.7, (6/10): 84.8, (6/4):				
		91.1, (3/13): 88.4, and				
		t weight is up 2# (3.4%) x/1				
		x/7 days, down 4# (4.7%)				
	, ,	5.7%) x/1 month and down				
		hs. On daily weights. Below				
		Body Mass Index: 15.53				
	(underweight). Had 3	+ Left LE edema and 2+				
		reports of edema now, on				
	Lasix. Potential risk for	or weight changes and				
	dehydration. Fluids e	ncouraged and dietary offers				
	15+ servings/day. Ha	s preventative treatment to				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		IL6012355	B. WING		07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	
CENTRAL	IA MANOR	1910 EAS	ST MCCORD RTE	161 EAST	
		CENTRA	LIA, IL 62801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETE
S9999	Supplement. Estimate kilo-calories per kg), kilo-calories per kg), kilo-calories per kg), kilo-calories), and 40-injury factor). Expect changes and with diu Supplements. 1). Dis Protein Supplement. at meals. R20's Dietitian Quarte 5/8/24: On a Pureed Protein Supplement. and supper. Super Color House Supplement will Intakes 25-75%. Weig (5/1): 92, (4/24): 93.8 (2/8): 101.8, and (11/1) down 9# (9.1%) x/3 in 18#(16.3%) x/6 mont IBW Range 105-134. (underweight). Had 3 Right LE edema, nor Lasix. Potential risk for dehydration. Fluids e 15+ servings/day. Had Coccyx. Skin tear bel to review. On Multivit. Needs: 1470 calories 1470 cc fluids (1 cc pgram protein (1.0-1.2 changes as edema cl therapy. PLAN: Clarif Discontinue High Cal	to review. On Multivitamined Needs: 1400 calories (35) 1400 cc fluids (1 cc per 48 gram protein (1.0-1.2) weight changes as edema retic therapy. PLAN: Clarify continue High Calorie High 2). ADD: House Supplement erly Assessment dated diet with High Calorie High Fortified Pudding at lunchereal at breakfast and with ice cream at meals. ghts: (5/8):92.5, (5/7): 95, (4/17): 90.5, (4/8): 93.1, 10): 110.5. Current weight is nonths, and down hs. On daily weights. Below Body Mass Index: 16.38 + Left LE edema and 2+ reports of edema now, on or weight changes and neouraged and dietary offers as preventative treatment to ow right knee. No new labs amin Supplement. Estimated (35 kilo-calories), and 42-50 injury factor). Expect weight hanges and with diuretic by Supplements. 1).	S9999		
	meals. On 07/08/24 at 11:57 sitting in front of her.	AM, R20 had her meal R20 appeared frail and thin ot eating, and no staff was			

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Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY IPLETED
		IL6012355	B. WING		07	7/12/2024
	PROVIDER OR SUPPLIER	1910 EA	ADDRESS, CITY, STATE AST MCCORD RTE A ALIA, IL 62801	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
\$9999	assisting her with eat beef tips, green bean gravy, bread, nutrition No fortified pudding w meal ticket listed fortinutritional supplement. On 07/08/24 at 11:59 Assistant/CNA) went she gave R20 a few to V27 then left and wer resident with eating. If given R20 just sat at front of her not eating unknown name did w standing and gave R2 food then left. On 07/08/24 at 12:01 resident she was assistanding gave R20 or again. On 07/08/24 at 12:03 then another staff meat the table across from another resident with during this time with rung this time with rung this time with rung. R20 mainly consupplement ice crean. On 07/09/24 at 11:50.	ing. R20's tray had pureed s, mashed potatoes with hal supplement ice cream. Was noted on tray. R20's fied pudding, ice cream and it on her meal ticket. AM, V27 (Certified Nurse over to R20 while standing bites of pureed beef tips. In back to assisting another after the few bites R20 was the table with her food in it. Another staff member alk up to the table while 20 a couple more bites of PM, V27 left another isting again and while he bite of her food then left in assist eating. R20 sat at the table in assistance. PM, R20 was taken out of PM it was noted that R20 han 25% of the food on her sumed her nutritional in. AM, R20 was noted in the I pureed polish sausage,	S9999			

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		· ,	(X3) DATE SURVEY COMPLETED	
			5.44440			
		IL6012355	B. WING		07	//12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CENTRAL	IA MANOR	1910 EAS	T MCCORD RT	E 161 EAST		
		CENTRAL	IA, IL 62801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	6	S9999			
	glasses of cranberry j feeding herself a few not assisted by staff w	n, fortified pudding, and two uice on her tray. R20 was bites of her meal. R20 was vith eating during this meal. was the few bites she gave				
	consumed less than 2 and was not assisted bites of her pureed po	PM it was noted R20 had 25% of the meal on her tray by staff. R20 had a few blish sausage, sauerkraut, t ice cream, and a few bites				
	room she was served potatoes with gravy, r fortified pudding, nutri	AM, R20 was in the dining pureed ham, mashed nixed vegetables, cake, tional supplement ice 0 was being assisted by				
	consumed around 50	nutritional supplement ice				
	R20 can feed herself eat on her own that steating. V8 said they dresidents at the facility who are at risk for we doesn't know where the it out with the intakes monitor. V8 said she amonitor intake list for supplements. V8 stated dining room sometimes	ne paper goes after they fill of the resident they do thought R20 was on the				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE	SURVEY PLETED
		IL6012355	B. WING		07	/12/2024
NAME OF D	ROVIDER OR SUPPLIER		DDDESS CITY STATE	ZID CODE		, , _ ,
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
CENTRAL	IA MANOR		ST MCCORD RTE : LLIA, IL 62801	161 EAST		
040.15	CLIMMADY CT				CTION	2/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S9999	Continued From page	e 7	S9999			
	residents a bite here assist all of them with stand up and feed residending several peoplifies bites and then go and give them a few his she has to do this offer. On 07/11/24 at 1:19P they don't monitor every people who have lost supplements. V9 said the meal intake sheet nutritional supplement mainly eat her nutritional supplement mainly eat her nutritional supplement mainly eat her nutritional supplement. V9 R20 at times with eath herself at times, but the seating good, they let if she doesn't know who people on the intake intake monitoring out. V9 stated that the second shift she said person in the dining residents that need her people most of the times residents that need and dining room. V9 said enough staff. On 07/11/24 at 1:55P	and there to be able to eating. V8 said she does sidents, because she is le at a times and will give a over to another resident bites of their food. V8 said en. M, V9 (CNA) stated that ery resident's intake only weight or on nutritional I that she thought R20 is on for weight loss and it. V9 stated that R20 will enal supplement ice cream ing, she doesn't touch a lot said that she does assist ing. V9 said R20 will feed they have to assist her at they notice someone isn't the nurse know. V9 said that o is responsible for putting monitoring sheet or where sheet goes after she fills it ey are short of staff on that there may be only one				
	V3 said if a resident is certified nurse assista	that are ordered by a doctor. sn't eating well that the ant will usually let the nurse ey notify the doctor of any				
	weight losses, and the	ey will give an order to				

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	IL6012355	B. WING		07/1	2/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
CENTRALIA MANOR	1910 EAST CENTRALIA	MCCORD RTI A, IL 62801	E 161 EAST		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	NT OF DEFICIENCIES BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
monitor the resident food intididn't know who all they had intake for. V3 said that R20 with eating, but if she doesn should be assisting her. V3 had a weight loss or not. V3 never seen the meal intake certified nurse assistants had intake of certain people with thought R20 was on the list said that R20's intakes should be assisted that R20's intakes should lectronic medical record if V3 didn't know why R20 didner chart since 12/07/23. On 07/11/24 2:00PM, V4 (Disaid that they monitor intake times four weeks, and anyous significant weight change. Vout a meal intake sheets dad down intakes, but she doesn afterwards. V4 said that she it and then input the informate electronic medical record. Vous need to add someone to the usually gets an email. V4 said that R20 was on the meal intake sheet in a while. V10 said the receive the meal intake sheet in a while. V10 said the receive the meal intake sheet on On 07/11/24 at 2:15PM, V10 was on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN) stated that she had not on the meal intake sheet or On 07/11/24 at 2:15PM, V11 Nurse/RN)	d orders to monitor can assist herself n't eat then staff was unaware if R20 3 said that she has sheets that the ad to write down the h weight loss. She to be monitored. V3 uld have been in the they are monitoring it. dn't have no intakes in Dietary Supervisor) es of new admission one that has a V4 said that she prints aily for staff to write sn't know who gets it the thinks the nurses get action into the V4 said when they the intake sheet she aid that she has no takes sheets. V4 said that she has no takes sheets. V4 said that she does not the sheet she has no the sheet sheet she has no the sheet sheet she has no the sheet sheet she has no the sheet s	\$9999			

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
	IL6012355	B. WING		07	//12/2024
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CENTRALIA MANOR	1910 EAS	ST MCCORD RTE	161 EAST		
JENTRALIA MANOR	CENTRA	LIA, IL 62801			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
said they monitor all the care unit's meal intake monitor the intake of the care unit's meal intake monitor the intake of the care unit into the intake of the care into t	time for the other halls. V11 he resident on the memory e, but she doesn't think they he other residents. M, V26 (RN) stated that she ntake sheets and she does kes in for any resident in the cord. V26 said the only input fluid intake. V26 said en the meal intake sheet. M, V2 (Director of that he has never seen the t documents percentages of cok in. V2 said that he is nd is still trying to learn nsure if R20 was on the f R20 has had a weight loss. D's meal assistance needs. esident is not eating and if should be assisting any elp or not eating on their AM, V28 (Registered the believes that the facility all intakes because it is their meal intake recording is so that they pick and choose to monitor. V8 said that she all. V8 said that she doesn't myone even though she at of food intake they have the certified nurse assistants etting them know if well. V28 stated that even	S9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICAT	ION NUMBER	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7.1.5 . 2	A. BUIL	DING:	00 22.125
IL60123	55 B. WING	·	07/12/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
CENTRALIA MANOR	1910 EAST MCCOF CENTRALIA, IL 62		
(X4) ID SUMMARY STATEMENT OF DEFICE PREFIX (EACH DEFICIENCY MUST BE PRECE TAG REGULATORY OR LSC IDENTIFYING II	DED BY FULL PREI	EIX (EACH CORRECTIVE	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE
R20's chart she obtained her meal in percentages from some of the certificassistants and the progress notes. It wasn't much about meal intakes in the stated that she didn't know if R20 result assistance with meals, but if R20 is get assistance with meal she expect assist her. V28 said that she recommended supplements like ice cream, nutrition would expect the staff to offer and meals the resident receive these supplements at remotely. V28 said that if R20 had a loss she would have noticed it and printervention in place. V28 was unsurrequired any assistance with meals. They notified the doctor recently about a weight loss she will look at her we when she comes in next time or do in R20's Progress Note dated 07/10/24 "Weight loss report received. R20 (resident) currently a Puree diet with house supplement." primary doctor, awaiting orders. The facility policy titled "Weight Monobjective states to consistently asset for significant weight loss or gain. The Facility Policy "Food Service" we date of 09/2010 documents in part uprocedure the nursing staff shall be for observing the resident's food accrecord the intake on the provided medocumentation into POC (Point of Cintake) only for those residents that	ed nurses /28 said there he notes. V28 quired supposed to s staff to mends hal shake and hake sure that ents. V28 said ry other week them large weight but a new re if R20 V28 said if fut R20 having ights and diet it from home. If at 1:17PM esident) had over the last daily weight. Notified ittoring" ss residents ith a revised inder responsible eeptance and		

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6012355	B. WING		07/	12/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CENTRAL	IA MANOR		Г MCCORD RT IA, IL 62801	E 161 EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
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