STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047225	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRALIA MANOR	1910 EAST MCCORD RTE 161 EAST , CENTRALIA, Illinois, 62801

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S0000	Initial Comments Complaint Investigation #2558205/2602393 - F678 A partial Extended Survey was conducted. - F940, F941, F942, F946, F947, and F949	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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. These regulations were not met as evidence by:	S9999		

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

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S9999	Continued from page 1 Based on interview and record review the facility failed to initiate cardiopulmonary resuscitation (CPR) timely for 1 of 3 (R1) residents reviewed for death in the sample of 11. This failure resulted in facility staff not initiating CPR for 10-15 minutes after finding R1, who had chosen to be a full code with full treatment, in bed with no pulse and no respirations. CPR was not initiated until V11 (RN/Registered Nurse) was told by oncoming staff that R1 was a full code. After CPR was initiated, R1 was transferred via ambulance to the local hospital and pronounced dead. Findings include: R1's undated Resident Face Sheet documents R1 was admitted to the facility on 8/15/25 with diagnoses that include atrial fibrillation, acute respiratory disease, diabetes, chronic obstructive pulmonary disease, heart failure, pleural effusion, chronic kidney disease, and hypertension. R1's MDS (Minimum Data Set) dated 8/22/25 documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R1 was cognitively intact. R1's POLST (Practitioner Order for Life-Sustaining Treatment) form dated 8/6/2025 documents under Orders for Patient in Cardiac Arrest a check mark next to "Yes CPR: Attempt cardiopulmonary resuscitation (CPR). Utilize all indicated modalities per standard medical protocol." This same form documents under Orders for Patient Not in Cardiac Arrest a check mark next to, "Full Treatment Primary goal is attempting to prevent cardiac arrest by using all indicated treatments. Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated." This indicates if R1 was found with no pulse and no respirations all treatments should be attempted to revive R1. R1's Physician Order Report dated 8/15/25 to 8/31/25 documents in bold print next to R1's name "Full code." R1's current Care Plan documents the following header, "Care Plan- (R1) (Full Code)…" R1's Vitals Report dated 8/26/25 documents the following vital signs 2:01 AM- blood pressure 137/75, oxygen saturation 96%, respirations 20 per minute, pulse 65 per minute; 2:47 AM - temperature 98.1 degrees Fahrenheit, pulse 74/per minute, respirations 20 per	S9999		

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S9999	Continued from page 2 minute, blood pressure 112/54, oxygen saturation 98%. R1's Medication Administration History dated 8/26/25 documents R1's blood sugar was checked between 5 and 7 am with the result documented as 173. R1's Progress Notes document the following on 8/26/25: 2:48 AM, "Continues on droplet precautions r/t (related to) Covid-19. Lungs diminished, no cough or SOB (shortness of breath) at this time. Vitals obtained Q (every) 4 hours. Will continue to monitor." Signed by V11 (Registered Nurse/RN) 6:34 AM, "CNA (Certified Nursing Assistant) came to signee stating resident not breathing and pulseless. CPR (cardiopulmonary resuscitation) initiated and 911 notified." Signed by V11 (RN) 6:35 AM, "signee entered facility and was informed of resident's passing. Signee then alerted staff that resident was a full code, and that CPR was needed STAT. crash cart taken to resident's room. 911 called per floor nurse." Signed by V3 (Licensed Practical Nurse/LPN). 6:40 AM, "(initials of ambulance service) here at this time x (times) 2 personnel. Attempted to reach both spouse, and daughter (name of daughter) with no answer." 6:50 AM, "attempted to reach (V7/Physician) at this time with no answer. EMS (emergency medical services) leaving with compressions given." 7:10 AM, "MD (physician) notified of resident condition." 7:30 AM, "POA (power of attorney) notified of resident condition." 7:34 AM, "Hospital called to notify resident expired. Time of death 0712 (7:12 AM)." R1's local ambulance report documents on 8/26/25 at 6:36 AM the call was received, and the ambulance was dispatched to the facility and arrived at 6:41 AM. Under Patient Complaints the report documents Chief Complaint as "Cardiac Arrest (Primary)." Under Assessments and Comments the report documents R1 has no airway and no pulses. Under Narrative the report documents, "Vehicle 44 dispatched Lights and Sirens to respond immediately to (initials of facility) for a male pt (patient) in arrest. Arrived on scene to find	S9999		

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S9999	Continued from page 3 one staff member in pt's room performing CPR. Staff stated the pt was moving from his wheelchair to the bed and soon after went unresponsive…continued CPR for staff as EMS (Emergency Medical Services) placed pt on monitor showing asystole. Pt placed on EMS stretcher via 4-man sheet lift with strap x (times) 5…transfer initiated to (initials of local hospital) with radio report completed en route. EMS notes no changes in cardiac rhythm with meds (medications) or CPR. On arrival at (initials of local hospital) er (emergency room), pt transported inside and placed in bed via 2-man sheet lift…" R1's local hospital report dated 8/26/25 documents under ED (Emergency Department) Triage Notes, "Patient from (name of facility) …Full arrest. CPR in progress by EMS. Code called, ACLS (advanced cardiac life support) initiated…7:12 AM…. Time of death pronounced…. The patient is a 74-year-old male who present to the ED in cardiac arrest. The patient was in the NH (nursing home) attempting to transfer from the wheelchair into his bed when he went unresponsive. The patient failed to awaken or respond to the staff, so EMS was called. The patient was found to be in asystole. An IO (intraosseous device) was established, and CPR was in progress. A laryngeal airway was placed, and two rounds of epi were given without return of circulation. The patient remained in asystole the whole 20 minutes he was in the care of EMS." On 9/3/25 at 2:16 PM, V9 (CNA) stated she worked night shift beginning on 8/25/25 and ending on the morning of 8/26/25. V9 stated R1 put his call light on around 3:30 or 3:45 AM. V9 stated R1 had to go to the bathroom so she assisted him to the bathroom and onto the commode. V9 stated R1 put the light on when he was done, and she assisted him back to his room. V9 stated R1 wanted to stay up in his wheelchair so she asked him if he needed anything else and he said he didn't. V9 stated when she left his room he was sitting in his wheelchair with his walker beside him. V9 stated R1 was able to transfer from his wheelchair to his bed independently. V9 stated around 6 or 6:30 AM, she heard other staff yelling and asking if R1 was dead. V9 stated she went to R1's room and he was in bed and appeared dead. V9 stated during this time frame V11 (RN) stated twice R1 was a full code. V9 stated there were a lot of people with R1 so she finished taking care of other residents and was not involved in the care of R1. On 9/3/25 at 1:08 PM, V6 (CNA) stated she entered R1's room around 6:10 or 6:15 AM on the morning of 8/26/25. V6 stated R1 usually got himself ready so she just went in to make sure he was awake and ask him if he needed	S9999		

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S9999	Continued from page 4 anything before breakfast. V6 stated R1 appeared to be sleeping but his color was off, so she went closer to check on him. V6 stated R1 wasn't breathing so she called V4 (CNA) and V8 (CNA) to check him. V6 stated then she told the nurse (V11) they needed assistance. V4 stated V11 sat at the nurse's station and told them R1 was just fine. V6 stated V11 slowly came to R1's room and told them to get the nurse from the other hall. V6 stated as V11 entered the room she grabbed a stethoscope and checked R1's heart rate. V6 stated by the time V11 was done checking R1, V5 (RN) entered the room and checked for a heart rate and respirations. V6 stated they left the room after they verified R1 was not breathing and didn't have a pulse. V6 stated V3 (LPN) came in to work 10 or 15 minutes after she had first found R1 and asked if R1 was a full code or a DNR (Do Not Resuscitate) and she believed V11 answered and said R1 was a full code. V6 stated V3 said we have to do CPR. V4 stated V5 (RN) called for two people to go with her, and they went to R1's room to do CPR. V6 stated she continued getting other residents up since they had enough staff assisting with CPR. When asked if she had any concerns with the situation, V6 stated she thought V11 should have been "on top of it and not so casual." V4 stated she thought it was more serious than V11 was acting. On 9/3/25 at 12:44 PM, V4 (CNA) stated she came to work at 5:30 AM on the morning of 8/26/25. V4 stated they started getting residents up for breakfast on R1's hall about 6:00 AM. V4 stated they got up two residents and V6 (CNA) went to R1's room to wake him up. V4 stated V6 came to her and said she didn't think R1 was breathing. V4 stated she immediately went to R1's room and confirmed he wasn't breathing. V4 stated about 6:10 AM she yelled down the hall to V11, "Hey, come here he isn't breathing." V4 stated V11 was moving very slowly so she yelled again, "Hey, he isn't breathing. What do we do."? V4 stated V11 yelled back R1 was fine an hour ago when she checked his blood sugar. V4 stated V11 finally got to the room and got the stethoscope. V4 stated V5 (RN) arrived from the other side at that time and checked R1. V4 stated she thought they were going to call time of death since they hadn't started a code. V4 stated she was waiting on the nurse to tell her what to do. V4 stated V11 said he (R1) is gone. V4 stated V11 didn't say anything about R1's code status. V4 stated she started gathering supplies to clean R1 up for the funeral home to transport him. V4 stated she said, "So we were getting ready to clean him up and prepare him for the funeral home until V3 walked in and asked the obvious question." V4 stated then V5 grabbed the crash cart, and V10 (LPN) started compressions, while V11 (RN) was doing the rescue breaths with the	S9999		

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S9999	Continued from page 5 ambu bag. V4 stated she was standing on the side assisting as needed. V4 stated the plastic was still over the bag V11 was using so no air was getting to R1. V4 stated she told V11 the plastic was still over the bag and V11 laughed and removed the plastic. V4 stated V10 told V11 it wasn't funny. V4 stated the ambulance arrived quickly and the emergency personnel took over with the code. V4 stated she thought the failures were all V11. V4 stated V11 didn't know what she was doing, and she wasn't sure V4 checked R1 an hour before he coded. V4 stated the situation, "woke me up" and from now on she will look at the residents code status herself. V4 stated "We literally had the linens in our hand ready to clean him up for the funeral home." On 9/3/25 at 2:11 PM, V8 (CNA) stated on 8/26/25 she came to work at 5:30 AM. V8 stated she was scheduled for a different hall but was on R1's unit asking a question when V6 (CNA) went into his room to wake him up. V8 stated V6 got her and V4 (CNA) to check R1 because she didn't think he was breathing. V8 stated they were running down the hall and saw V11 and told her they didn't think R1 was breathing. V8 stated V11 just stood there and stated R1 was fine she had just checked his blood sugar. V8 stated she did a sternum rub on R1 and he didn't respond. V8 stated she left because V11 (RN), V5 (RN), and V4 (CNA) were all in R1's room so she began taking care of the other residents. V8 stated she felt like it wasn't urgent for V11 (RN). V8 stated she thought V11 should have responded better, and she felt like they didn't have the help from V11 they needed. On 9/3/25 at 1:01 PM, V5 (RN) stated she was working on the other side of the facility when V12 (CNA) came to her and told her they needed her on the other side. V5 stated V12 didn't tell her why they needed her. V5 stated she walked to the other side and V11 was sitting behind the desk and told her a resident was dead and she thought he had expired "a while ago." V5 stated V11 wanted her to look for signs of life. V5 stated she went to R1's room and donned PPE (personal protective equipment). V5 stated V11 was with her, and they listened for heart and lung sounds and there were none. V5 stated she started back to her side and V3 (LPN) walked up and told her R1 was a full code. V5 stated she got the crash cart and started CPR. V5 stated R1 was pale bluish, with no signs of respirations or a heartbeat. When asked if she had any concerns, V5 stated, "Yes, I wish I would have started CPR earlier." When asked how long it was from the time R1 was found until they started CPR, V5 stated she wasn't sure. On 9/8/25 at 10:32 AM, V12 (CNA Shift Coordinator)	S9999		

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S9999	Continued from page 6 stated she was working the day R1 passed away. V12 stated she got V5 (RN) for V11 (RN) and looked up R1's code status. V12 stated she was charting at the nurse's station when she heard V6 asking R1 if he was ready to get up. V12 stated she then heard them say they needed a nurse. V12 stated V11 asked them what they needed, and they said R1 wasn't breathing. V12 stated V11 got up and went to R1's room and told her to get the nurse from the other side of the facility. V12 stated she told V11, R1 was a full code and tried calling the nurse. V12 stated the nurse didn't answer so she ran to the other side and got V5 (RN). When asked if V11 was aware of R1's code status before entering his room the first time, V12 stated she was. V12 stated when she and V5 got to R1's hall they asked V11 if she started CPR and she stated she hadn't, "he is cold." V12 stated V3 came in and said you must do CPR no matter what since he was a full code. V12 stated she took the crash cart to R1's room and left because they had plenty of staff in the room. When asked if she had any concerns with how the situation was handled. V12 stated her only concern was V11. V12 stated V11 wasn't a very good nurse. V12 stated V11 shouldn't have asked the CNA's why they needed her when they first asked for assistance, and she should have started CPR or instructed the CNA's to start CPR. On 9/3/25 at 12:32 PM, V3 (LPN) stated on 8/26/25 she clocked in for work about 6:30 AM. V3 stated she met V8 (CNA) in the hallway who seemed upset and told her they had "lost" R1. V3 asked V8 what she meant by lost and V8 told her R1 had passed away. V3 stated she asked if they were coding R1 and V8 stated they weren't. V3 stated she told V8, R1 was a full code, put her stuff down, grabbed the crash cart and went to R1's hall. V2 stated V5 (RN) and V11 (RN) were at the nurses station, and she asked V11 why they weren't doing CPR. V3 stated she put PPE on because R1 had tested positive for Covid previously and went to R1's room to assist with the code. V3 stated V11 called 911 and then relieved V3. V3 stated she didn't know why they hadn't started CPR immediately. V3 stated V11 made the comment R1 was cold. V3 stated she told V11 it didn't matter what color they are or what their temperature is if they are a full code they do CPR on them. V3 stated R1 had been diagnosed with Covid 19, had a cough and they had gotten a chest x-ray, but he was ok the last time she saw him. V3 stated she thought V11 should have immediately initiated CPR and called for assistance. On 9/3/25 at 2:25 PM, V10 (LPN) stated she arrived to work on the morning of 8/26/25, clocked in, and walked around the facility. V10 stated she "saw chaos." V10 stated by the time she got to the area, she was told by	S9999		

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S9999	Continued from page 7 staff R1 was unresponsive and they were getting ready to start CPR. V10 stated she went to help and started CPR. When asked what time it was V10 stated she clocked in about 6:30 AM. V10 stated she didn't have any concerns with the care R1 received after she arrived. On 9/3/25 at 2:21 PM, this surveyor attempted to contact V11 via telephone. There was no answer and no voicemail set up. On 9/8/25 at 11:10 AM, V2 (Director of Nurses/DON) stated on 8/26/25 she arrived at the facility around 8:00 AM. V2 stated she was told R1 had passed away and there were some questions about CPR being initiated immediately. V2 stated after she talked to staff and got the timelines in place, they determined there was a 10–20-minute time frame R1 went without having CPR initiated. V2 stated V3 came in around 6:30 AM on 8/26/25 and heard R1 had passed away, and they weren't doing CPR. V2 stated V3 started the process of coding R1 and called 911. When asked if during the investigation she was able to determine what happened and why they didn't initiate CPR immediately upon finding R1 with no respirations and no heartbeat, V2 stated it was a little hard with some time frames being off. V2 stated V11 (RN) placed the blame on everyone else. V2 stated she spoke with V11 (RN) on the phone and V11 admitted she didn't start CPR immediately and then hung up on V2. V2 stated she believed the issue was isolated to V11. V2 stated she knows a full code was called out by one of the CNA's and V11 didn't prompt any movement to begin CPR. V2 stated V11 said R1 was cold and gone and they weren't going to bring him back. V2 stated the CNA's were following V11's lead and had even gotten the supplies to clean R1 up for transfer to the funeral home. When asked what she did next, V2 stated they immediately started educating staff and it was completed with everyone working that day and all other staff when they returned to work or via telephone. V2 stated they educated on CPR, how to find code status, and what to do if a resident expires and is a full code. V2 stated they are doing continued education and auditing the training every week to ensure staff retain the training. V2 stated part of the training was also educating the CNA staff they could initiate a code without nurse guidance. V2 stated R1's code status was accurate and available for the staff to find. V2 denied any system failure related to this incident. On 9/3/25 at 3:47 PM, V1 (Administrator) stated right before she arrived at the facility on the morning of 8/26/25 she got a call from V3 (LPN). V1 stated V3 told her emergency medical services had been called for R1	S9999		

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S9999	Continued from page 8 and explained what happened to V1. V1 stated once she arrived at the facility she began talking to staff. V1 stated her investigation found V11 checked R1's blood sugar around 5:55 AM and R1 wanted to stay up in his wheelchair. V1 stated she spoke with CNA's, and they told her they went into R1's room around 6:10 or 6:15 AM and R1 appeared to be unresponsive. V1 stated they notified V11, and once code status was confirmed they got the crash cart and V3 and V10 started CPR. After reviewing the staff interviews with V1 this surveyor asked her what the outcome of her investigation was, V1 stated it should not have taken 15 minutes to initiate CPR. V1 stated she reached out to V11, and she wasn't very forthcoming. V1 stated V11 was supposed to come to the facility and talk and she didn't show up and couldn't be reached by phone. V1 stated V11 effectively terminated herself by not showing up. On 9/3/25 at 2:00 PM, V7 (Physician) stated he saw R1 the day before he passed away. When asked if he considered R1 to be end of life, V7 stated on 8/25/25 R1 seemed to be stable but had a lot of comorbidities including cardiac problems and Covid. When asked if the facility staff would have initiated CPR earlier if it would have changed the outcome, V7 stated, "I doubt it. He (R1) had significant comorbid condition. You can never know for sure." When asked what his expectations as the physician would be if they found a resident with no pulse and no respirations who was a full code, V7 stated, "Do CPR and send them to the hospital as soon as possible." The facility Policy 3.06 on "Emergencies" documents, "It is the policy of the facility to provide emergency care to a resident in need of it…. Emergency Care Procedure: 1. Nurse in charge of resident will evaluate resident's condition. If help is needed and there is more than one nurse available, the nurse assigned to resident will stay with resident and send another staff member to get another nurse. The staff member will also bring emergency equipment if needed. A nurse will notify resident's physician and follow orders received. Call ambulance, notify family, and complete transfer form. Call emergency room and let them know resident is on the way….Documentation of treatment and resident's response during emergency must be done in clinical record….I. Cardiac Arrest: When the facility has only one (1) employee on duty, that employee shall have been certified within the past twelve (12) months in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is more than one (1) person on duty in the facility, at least one (1) person on duty shall be so certified. Any facility employee who is on duty	S9999		

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CENTRALIA MANOR	1910 EAST MCCORD RTE 161 EAST , CENTRALIA, Illinois, 62801

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S9999	Continued from page 9 may be utilized to assist in these medical emergencies. Signs and Symptoms: 1. Immediate loss of consciousness. 2. Absence of palpable carotidal or femoral pulse. 3. Absence of audible heart sounds. 4. Absence of breath sounds or air movement throughout the nose or mouth. 5. Convulsions (may or may not be present). 6. Dilation of pupils of eyes. 7. Ashen gray color. Treatment: 8. Note the time as soon as the cardiac arrest is determined. Summon help immediately. 9. Provide CPR if determine appropriate according to the POLST/DNR form. CPR should be performed in accordance with the guidelines set by American Heart Association or the American Red Cross. 10. Utilize AED (Automated External Defibrillator) according to instructions on machine for use…." "A"	S9999		