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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145241 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/12/2024 |
| NAME OF PROVIDER OR SUPPLIER Helia Southbelt Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 101 South Belt West Belleville, IL 62220 | |

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) |
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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45302</p> <p>Based on record review and interview the facility failed to ensure 1 of 3 resident's (R6) prescription eye drops were documented as administered per professional standards regarding medication administration/documentation in a sample of 3.</p> <p>Findings include:</p> <p>R6's Undated Face Sheet, documents R6 was initially admitted to the facility on [DATE] with a diagnosis of glaucoma.</p> <p>R6's Physician's Order Sheet (POS), dated 4/2024 documents an order Latanoprost 0.005% 1 gtt (drop) both eyes at bedtime.</p> <p>The Reorder Fill History from the facility's pharmacy documents Latanoprost 0.005% eye drops were not refilled for the month of 4/2024.</p> <p>R6's Medication Administration Record (MAR) dated 4/2024 documents Latanoprost 0.005% was documented administered for all the days.</p> <p>R6's POS, dated 11/2024 documents Latanoprost 0.005% 1 gtt both eyes at bedtime.</p> <p>R6's MAR, dated 11/2024 documents Latanoprost 0.005% was administered on 11/1/2024. It was documented as a T for 11/2/2024 through 11/4/2024 - legend identified T as therapeutic leave. It was documented as administered on 11/5/2024 through 11/18/2024, 11/19/2024 was blank, 11/21/2024 through 11/23/2024 therapeutic leave, 11/24/2024 through 11/26/2024 initialed by staff as administered, 11/27/2024 blank.</p> <p>On 12/11/2024 at 2:20 PM V25, Pharmacy Order Entry Technician, stated (R6's) prescription eye drops Latanoprost 0.005% was not refilled or delivered to the facility to be administered for the months of April 2024 and November 2024 and they would have ran out because the eye drop bottle is a 25 day supply if administered every day per physician's orders.</p> <p>R6's MAR dated 11/2024 documents V31, Licensed Practical Nurse/LPN, administered Latanoprost 0.005% was administered at 9:00 PM on 11/15/2024.</p> <p>(continued on next page)</p> |

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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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 12/12/2024 at 8:50 AM V31 stated when she documented on R6's MAR a medication was administered that means the medication was available at the facility to administer and they do not why pharmacy would say it wasn't refilled because it was available and administered per physician's orders.</p> <p>R6's MAR dated 11/2024 documents V29, LPN administered Latanoprost 0.005% at 9:00 PM on 11/6/2024, 11/7/2024, 11/10/2024, 11/11/2024, 11/17/2024 and 11/18/2024.</p> <p>On 12/12/2024 at 9:08 AM V29 stated when she documented on R6's MAR a medication was administered that means the medication was available at the facility to administer and they do not why pharmacy would say it wasn't refilled because it was available and administered per physician's orders.</p> <p>R6's MAR dated 11/2024 documented V30, LPN administered Latanoprost 0.005% at 9:00 PM on 11/20/2024 and 11/26/2024.</p> <p>On 12/12/2024 at 9:20 AM V30 stated when she documented on R6's MAR a medication was administered that means the medication was available at the facility to administer and they do not why pharmacy would say it wasn't refilled because it was available and administered per physician's orders.</p> <p>On 12/12/2024 at 9:28 AM V2, DON (Director of Nurses) stated she noted on the pharmacy refill sheet that (R6's) eye drop Latanoprost 0.005% was not refilled in April 2024 and November 2024 and if it's a 25 day supply then she didn't understand how staff were documenting the eye drop was administered if it wasn't refilled by the pharmacy.</p> <p>The Facility's Medication Administration Policy effective 10/25/2014 documents, Medications are administered as prescribed in accordance with good nursing principles and practices and only be persons legally authorized to do so. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45302</p> <p>Based on observation, record review and interview the facility failed to use a gait belt during a one person transfer, and failed to implement fall precautions for 2 of 2 residents (R7, R11) in a sample of 21 reviewed for falls.</p> <p>Findings include:</p> <p>1. R11's Undated Face Sheet, documents he was initially admitted to the facility on [DATE] with a recent readmission from the hospital on 11/21/2024.</p> <p>R11's Minimum Data Set (MDS) dated [DATE] documents severely cognitively impaired, substantial/maximal assistance with toilet transfer.</p> <p>R11's Care Plan documents problem: ADLs (Activities of Daily Living) functional status/rehabilitation potential. R11 required extensive assistance x1 with most ADLs. Transfers via assist x1 with use of gait belt. Wheelchair is primary mode of transportation. Goal: R11 will gain strength and ADL independence to d/c (discharge) to home. Problem: R11 is at risk for falls related impaired mobility. Goal: R11 will remain free from injury. Approaches: place bed in lowest position while resident is in bed, place resident in a fall prevention program, staff with frequent reminders to res (resident) to call for asst (assistance) by using call light. Give resident verbal reminders not to ambulate/transfer without assistance. Keep call light in reach at all times. Keep personal items and frequently used items within reach.</p> <p>R11's Resident Progress Note, dated 11/15/2024 documents he was sent to local hospital unresponsive and faint pulse. He was admitted for altered mental status.</p> <p>R11's Resident Progress Note, dated 11/21/2024 documents resident returned back to facility at 3:38 PM.</p> <p>R11's Transfer Assessment, dated 11/27/2024, documents resident is not independent in transfers or ambulation. Assessment complete use gait belt with 1 assist with all transfers.</p> <p>R11's Fall Risk Assessment, dated 11/27/2024, documents he is high fall risk.</p> <p>R11's Fall Risk assessment dated [DATE], document moderate fall risk.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 12/11/2024 at 10:20 AM, V19, Certified Nurse Assistant/CNA, observed propelling R11 to his bathroom. V19 instructed R11 to grab the handrail that was located right in front of the toilet in his room. V19, CNA, pulled on R11 left arm to get him to stand up. R11 started to sit down and V19 told him to step back because he wasn't on the toilet and R11's feet started to slide from under him. V19 grabbed R11's left arm to attempt to pull him up and his feet slid from under him and then V19 fell on top of R11. R11 hit the bathroom wall with his right side. R11 stated, S*** you dropped me! after he fell. V19 didn't have a gait belt on R11 when he fell. V19 then left the bathroom and reentered the bathroom at 10:24 AM with a gait belt. V19 put a gait belt around R11 and attempted to get him off the floor. V19 wasn't able to get R11 off the floor by herself so she got V20, CNA, entered the room and V19 told V20 that R11 didn't fall that she lowered him to the floor and they attempted to get R11 off the floor, they were not able able to get R11 off the floor. V21, Physical Therapy Assistant/PTA, was in the hallway at that time and V19 called him into the room. R11 was still on the floor at that time and V21 went to R11's left side, V20 went to R11's right side and V19 pulled up R11's depend and pants. V21 and V20 did a 2 person transfer and assisted R11 into his wheelchair and V19 assisted in pulling up R11's pants. When V21 entered R11's bathroom and witnessed him laying on the floor he didn't ask staff what occurred or why R11 was on the floor, he just assisted with the transfer.</p> <p>On 12/11/2024 at 10:32 AM V20, CNA stated she didn't know what exactly occurred with R11 but that V19, CNA, told her she lowered him to the floor and she was there to attempt to help him up off the floor.</p> <p>On 12/11/2024 at 11:15 AM V21, PTA, stated when he entered R11's bathroom R11 was already in his wheelchair and he assisted the CNAs to pull his pants up. No staff told him R11 was lowered to the floor or just had a fall.</p> <p>On 12/11/2024 at 11:20 AM V20, CNA, stated her and V19, CNA, 2 person transferred R11 from the floor to his wheelchair that morning.</p> <p>On 12/11/2024 at 1:05 PM V23, R11's POA (Power of Attorney) stated the facility nurse called her today and notified her that the resident slid down the wall and it wasn't a fall. V23 stated she's in healthcare and she knows if you break the plane it's considered a fall. V23 was upset the facility nurse stated R11 didn't fall because she knows he did.</p> <p>On 12/11/2024 at 10:40 AM, in a joint interview with V1, Administrator and V2, Director of Nursing/DON, V2 stated not all residents require a gait belt during a 1 person transfer but if the resident's transfer status evaluation documents how each resident should transfer. When a resident goes out to the hospital and is readmitted to the facility therapy should reevaluate the resident's transfer status to ensure it hasn't changed. V2 stated when a resident has a fall staff should notify the nurse immediately so the resident can be assessed for injuries. If a resident falls and staff fall on top of the resident that is not considered the resident being lowered the floor that is considered a fall.</p> <p>45947</p> <p>2. R7's Face Sheet documents R7 was admitted to the facility on [DATE] with diagnoses including dementia and pain.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R7's Minimum Data Set (MDS) dated [DATE] documented R7 was severely cognitively impaired, required substantial assistance with bed mobility and transfer, and ambulated via wheelchair.</p> <p>R7's Care Plan dated 12/1/24 documents R7 is at risk for falls related to cognitive impairments.</p> <p>R7's Fall Risk assessment dated [DATE] documented R7 was at risk for falls.</p> <p>R7's Fall Investigation dated 12/1/24 documents R7 had a witnessed fall in the hallway. R7 was leaning forward in her wheelchair and fell to the floor, hitting her face and nose. R7 was sent to the hospital and found to have a broken nose. The intervention added was to have resident's wheelchair seat dumped.</p> <p>On 12/11/24 at 11:30 AM, R7 was sitting in wheelchair in room. The wheelchair seat was not dumped. V18, R7's Family, was visiting and stated that is the same wheelchair she has always had and they have not done anything with the seat.</p> <p>On 12/11/24 at 11:58 AM, V21, Physical Therapy Assistant (PTA), stated wheelchair modification is a joint effort between therapy and nursing. He was not aware of R7 getting a new wheelchair or having any recent modifications.</p> <p>On 12/11/24 at 12:40 AM, V22, Registered Nurse (RN), stated therapy does the dump seats on the wheelchair.</p> <p>On 12/11/24 at 1:50 PM, V2, Director of Nursing (DON), stated fall interventions should be implemented after discussing them at the morning meeting.</p> <p>R7's Fall Investigation dated 12/8/24 documents R7 had a witnessed fall. The location of the fall was not documented. The intervention added was 15 minute checks for safety.</p> <p>R7's Medication Administration Record (MAR) for December 2024 documents 15 minute checks were not started until 12/10/24.</p> <p>On 12/12/24 at 12:49 PM, V2, DON, stated she expects progressive fall interventions to be implemented after all falls.</p> <p>The Facility's Falls Management Policy documents, It is the policy of (Facility) to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions.</p> | | |

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| <p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947</p> <p>Based on interview and record review, the Facility failed to provide timely and reliable transportation for medical care for 1 of 3 residents (R2) reviewed for provision of medically related social services in the sample of 21.</p> <p>Findings include:</p> <p>1-R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including dementia, heart failure, weakness, and need for assistance with personal care.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documented R2 was severely cognitively impaired, required partial assistance with bed mobility, required substantial assistance with transfer, and ambulated via wheelchair.</p> <p>R2's Appointment Calendar for the month of November 2024 documents R2 had an appointment with a MD (Medical Doctor) scheduled on 11/18/24 at 11:00 AM.</p> <p>The Facility's Grievance/Concern/Complaint Form from V15, R2's Family, on 11/18/24 documents, (R2) was late for her doctor's appt (appointment) today. This is the third time appt rescheduled. Transportation ran late w/another appt. Dr (Doctor) refused to see resident. Appt was rescheduled.</p> <p>On 12/10/24 at 10:45 AM, V4, Transportation Driver, stated the transportation schedule book disappeared, so resident appointments were missed. He stated sometimes there are multiple resident appointments around the same time that have to be rescheduled because there is only one van and thinks R2 has missed two appointments due to overcrowding of schedule.</p> <p>On 12/10/24 at 12:58 PM, V1, Administrator, stated, Our previous transportation driver was terminated, and the schedule went missing, so I know (R2) missed her appointment. We rescheduled that one, and unfortunately another resident's appointment went too late, and she missed the second one.</p> <p>The Facility's Resident Rights Policy revised 8/31/23 documents, The Resident has a right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the Facility. The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident.</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45302</p> <p>Based on record review and interview the facility failed to ensure 1 of 3 residents (R6) medication were refilled by the pharmacy or delivered to the facility for prescribed eye drops regarding medications per physician's orders in a sample of 3.</p> <p>Findings include:</p> <p>R6's Undated Face Sheet, documents R6 was initially admitted to the facility on [DATE] with a diagnosis of glaucoma.</p> <p>R6's Physician's Order Sheet (POS), dated 4/2024 and 11/2024 documents an order Latanoprost 0.005% 1 gtt (drop) both eyes at bedtime.</p> <p>On 12/11/2024 at 2:20 PM V25, Pharmacy Order Entry Technician, stated (R6's) prescription eye drops Latanoprost 0.005% was not refilled or delivered to the facility to be administered for the months of April 2024 and November 2024 and they would have ran out because the eye drop bottle is a 25 day supply if administered every day per physician's orders.</p> <p>The Reorder Fill History from the facility's pharmacy documents Latanoprost 0.005% eye drops were not refilled for the month of 4/2024 and 11/2024.</p> <p>On 12/12/2024 at 9:28 AM V2, DON (Director of Nurses) stated she noted on the pharmacy refill sheet that (R6's) eye drop Latanoprost 0.005% was not refilled in 4/2024 and 11/2024. The nurses are responsible for notifying pharmacy for all medication refills monthly because if the nursing staff doesn't order the medication then it doesn't get delivered to the facility.</p> <p>The Facility's Medication Administration Policy effective 10/25/14 documents, Medications are administered as prescribed in accordance with good nursing principles and practices and only be persons legally authorized to do so. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.</p> |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45302</p> <p>Based on record review and interview the facility failed to ensure 1 of 3 residents (R6) medication administration record was accurately documented for physician prescribed eye drops regarding documentation of medication administration in a sample of 3.</p> <p>Findings include:</p> <p>R6's Undated Face Sheet, documents R6 was initially admitted to the facility on [DATE] with a diagnosis of glaucoma.</p> <p>R6's Physician's Order Sheet (POS), dated 4/2024 documents an order Latanoprost 0.005% 1 gtt (drop) both eyes at bedtime.</p> <p>The Reorder Fill History from the facility's pharmacy documents Latanoprost 0.005% eye drops were not refilled for the month of 4/2024.</p> <p>R6's Medication Administration Record (MAR) dated 4/2024 documents Latanoprost 0.005% was documented administered for all the days.</p> <p>R6's POS, dated 11/2024 documents Latanoprost 0.005% 1 gtt both eyes at bedtime.</p> <p>R6's MAR, dated 11/2024 documents Latanoprost 0.005% was administered on 11/1/2024, T was documented for 11/2/2024 through 11/4/2024 which means therapeutic leave, was administered on 11/5/2024 through 11/18/2024, 11/19/2024 was blank, 11/21/2024 through 11/23/2024 therapeutic leave, 11/24/2024 through 11/26/2024 initialed by staff as administered, 11/27/2024 blank.</p> <p>R6's MAR dated 11/2024 documents V31, Licensed Practical Nurse/LPN, administered Latanoprost 0.005% was administered at 9:00 PM on 11/15/2024.</p> <p>On 12/12/2024 at 8:50 AM V31 stated when she documented on R6's MAR a medication was administered that means the medication was available at the facility to administer and they do not why pharmacy would say it wasn't refilled because it was available and administered per physician's orders.</p> <p>R6's MAR dated 11/2024 documents V29, LPN administered Latanoprost 0.005% at 9:00 PM on 11/6/2024, 11/7/2024, 11/10/2024, 11/11/2024, 11/17/2024 and 11/18/2024.</p> <p>On 12/12/2024 at 9:08 AM V29 stated when she documented on R6's MAR a medication was administered that means the medication was available at the facility to administer and they do not why pharmacy would say it wasn't refilled because it was available and administered per physician's orders.</p> <p>R6's MAR dated 11/2024 documented V30, LPN, administered Latanoprost 0.005% at 9:00 PM on 11/20/2024 and 11/26/2024.</p> <p>(continued on next page)</p> | | |

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