STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145241	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Southbelt Healthcare	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interview and record review the facility failed to notify the responsible party of a change in condition for 1 out of 3 residents, (R4); reviewed for Resident Rights in a sample of 11. Findings include: R4's face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, dementia, chronic kidney disease, and Alzheimer's disease. R2's Minimum Data Set (MDS) dated [DATE], documented staff were unable to complete the interview to determine R4's Brief Interview of Mental Status (BIMS); it does document R2's cognitive skills for daily decision making are severely impaired and inattention is continuously present, does not fluctuate. R4's Care Plan last revised on 2/18/25, documented she has a communication deficit related to Alzheimer's dementia with interventions of, in part, to communicate with family to determine what works best for resident which was started on 12/03/2024. Wound Management details dated 4/17/25, documented R4 had a skin tear to her right ankle identified on 4/17/25 at 2:40 PM. R4's Medication Administration Record documented Silvadene (silver sulfadiazine) (SSD)cream; 1 %; Amount to Administer: nickel size; topical order once a day, clean right ankle with normal saline daily and as needed apply SSD cream, collagen powder and cal-alg (calcium alginate) and cover with island dressing; diagnosis unspecified skin changes dated 4/17/2025 - 4/21/2025. MAR shows the SSD cream was signed off as administered on 4/17/25-4/21/25. On 4/30/25 at 2:37 PM, V5, family member, stated the facility had notified her on 4/1/25 that R4 had a blister on her ankle, and on 4/6/25 she visited R4, the blister was gone. On 4/25/25 V5 stated she visited R4 and noticed oozing on her right sock and asked the nurse to look at it. V4 stated R4 had an open wound covered by some gauze she was never told about. V5 stated R4's nurse told her she only noticed it that day (4/25/25) and was instructed to put betadine on it and cover it up. V5 stated she thinks R4 got the wound from rubbing up against a board that is on her wheelchair. (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 12:27 PM, V16, Licensed Practical Nurse/LPN, stated she had notified V5 of R4 having a blister on her right ankle. V16 stated she was off for 8 days after that and came back on 4/25/25 when she noticed R4's wound had deteriorated but there were already treatment orders in place for it. V16 stated V5 said she didn't know about her wound and asked to see it that day and asked what was being done to it. V16 stated she showed her it and it was not an opened wound and they were using betadine with a dry dressing over it. V16 stated she doesn't know when V5 was notified of R4's wound deterioration. On 5/1/25 at 12:45 PM, V14, wound nurse, stated R4 had initially had a wound on her right ankle on 4/1/24, the wound doctor assessed it on 4/7/25 and it had already cleared up. V14 stated R4's right ankle wound opened up to a skin tear and new treatment orders were placed. V14 stated she remembers the POA (Power of Attorney) being present when they put new treatment orders in during rounds which take place every Monday which would have been 4/21/25. On 5/1/25 at 1:30 PM, V15, LPN, stated she was not sure the exact date R3's POA was notified of her wound but on 4/21/25, she remembers V5 being at the facility because she had asked if we could keep R4's wound covered, and we ended up getting new orders for that. On5/5/25 at 2:50 PM, V2, Director of Nursing (DON), stated the facility does not upload the 24-hour report form, that is something for the nurses to have for communication and we would not have after this amount of time. V2 stated she would expect a change in condition to be reported within the same shift it occurred and any attempts to contact the POA (Power of Attorney) to be documented. On 5/1/25 at 1:58 PM, V1, Administrator, stated there is no documentation that R4's POA was notified of her change in condition for her wound. V1 stated she would have expected staff to document and report this change in condition right away. The facility's Change in Condition Policy dated 2/2012, documented, Notification of physician and/or responsible parties shall be documented in the clinical record as well as the 24 hour report form. Status changes, which are not significant enough to be reported, must also be documented in the medical record. The Change in Condition Policy continued to document, It is the responsibility of the nursing staff to inform the resident's medical contact of any change of condition. Appropriate follow through from shift to shift is imperative for all residents with any change in condition. The nursing staff must utilize the tools provided for formal communication from shift to shift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews and record reviews the facility failed to ensure medications were completely administered and failed to accurately document the administration of medications for 1 out of 4 residents, (R2) reviewed for Pharmacy Services in a sample of 11. Findings include: R2's face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, adrenocortical insufficiency, neuromuscular dysfunction of bladder, type two diabetes mellitus, and hypertension. R2's Minimum Data Set (MDS) dated [DATE], documented she was cognitively intact. R2's Care Plan last revised on 3/11/25 documented she presented with non-compliant behavior as evidenced by refusing medication due to wanting to take medications on her own time rather than while nurse is in her room. R2's Medication Administration Record (MAR) dated 4/27/25 documented that she was ordered to receive the following medications by mouth that could have been left in a pill cup, hydrocortisone 10 mg (milligram) tablet, hydrocortisone 5 mg tablet, fludrocortisone 0.1 mg tablet, methimazole 10 mg tablet, toprolol 100 mg tablet, atorvastatin 10 mg tablet, and amlodipine 2.5 mg tablet. The MAR documented all these medications were scheduled to be given between 7:00 AM and 10:00 AM. R2's MAR documented all the above morning medications were administered and signed of on by V8, Licensed Practical Nurse (LPN). R2's Progress Note dated 4/27/25 at 11:41 AM, documented that V8 stated, This nurse went to administer resident medications and resident still had meds from this morning when She stated she would take them this morning when admin to her,resident still had meds from this morning and previous meds from the hs (night) before, the resident was educated that the pills should have been taken when they were given and that I can not leave them at her bedside. resident was educated that could be a safety hazard. Resident yelled for me to put the pills back on her table or she would be reporting me. The pills were removed at this time. Resident also refuses to get bs checked at this time. MD (medical director) notified. On 4/30/25 at 12:25 PM, V3, R2's daughter, stated R2 informed her that she woke up on 4/27/25 around 8:00 AM and heard someone come in her room while she was in the restroom, when she came out no one was there, and nothing was left. V3 stated R2 told her that the nurse came in around 10:00 AM with her morning medications but R2 fell asleep, and the nurse left them without making sure she took them. V3 stated R2 told her that at 11:45 AM the nurse came back to her room when she woke up and took her medications away refusing to let her take them because she didn't already. V3 stated R2 gets very important medications that should not be missed and asked the nurse to let R2 take them. V3 stated the nurse told her no, and was rude. V3 stated she also contacted the Director of Nurses (DON) and reported this but the only thing she said was that she would have to decide if disciplinary action is required. V3 stated R2 never did receive her morning medications on 4/27/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 12:53 PM, R2 stated she got her medications later that morning, after breakfast on 4/27/25 but usually takes them during breakfast. R2 stated she ended up falling asleep after the nurse placed them in her room and left; around 10:00 AM. R2 stated she woke up around 11:45 AM when the nurse came back and saw the medications she hadn't taken yet. R2 stated the nurse took the medications and told her she couldn't have them now since she didn't take them already. R2 stated she told the nurse she would like to still take her medications, but the nurse would not allow her to and left. R2 stated if the nurse really wanted me to take them at a certain time, she should have waited for me to take them while she was there instead of leaving them in my room. R2 stated she takes important medications in the morning she doesn't like to miss including steroids for her adrenal glands, and other medications for hypothyroidism and blood pressure that she didn't receive that day. On 5/1/25 at 11:50 AM, V8, licensed practical nurse (LPN), stated she usually leaves R2's medications in her room and she'll take them eventually but that day she had come back with R2's next dose of blood pressure medication and noticed she still had her cup of medications she'd left for R2 and a pill from the night before. V8 stated she did not want to let R2 take her morning pills at that time due to doubling up on the blood pressure medication. V8 stated R2 had fallen asleep and that was why she didn't take the medications and was mad she wouldn't let R2 take them late. V8 stated she notified the doctor through a message portal about R2's refusal but never heard back from him. V8 stated she did not ask the doctor if it would be okay for R2 to take her medications late. On 5/2/25 at 9:47 AM, V17, R2's Endocrinologist's Medical Assistant, stated R2's doctor said her steroids could have been given at a later time. On 5/1/25 at 9:00 AM, V1, Administrator, stated the entire facility follows the same medication pass policy. On 5/1/25 at 11:55 AM, V1, stated it sounds like the nurse left R2's pills for her to take and R2 fell asleep then too much time had passed for the nurse to feel comfortable giving them late. V1 stated the medications are supposed to be taken while the nurse is present unless they have an order for medications to be left at bedside. V2, Director of Nursing (DON), stated V8 signed R2's medications off and when she didn't take them, the only way to document they weren't given is to make a progress note. V1 stated the doctor could have been called to see if the medication could be taken late. The facility's Medication Administration Policy dated 10/25/14 documented, When medications are administered by mobile cart taken to the resident's location (room, dining area, etc. (Et cetera)) medications are administered at the time they are prepared. Medications are not pre-poured. The Medication Administration Policy continued to document, The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate. The Medication Administration Policy also documented. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.