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	08/13/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to prevent resident to resident abuse for 1 of 6 residents (R3) reviewed for abuse in the sample of 8. This failure resulted in R3 having lacerations and bruising. Findings Include:On 8/13/25 at 1:00 PM, R3 was observed ambulating independently on the hallway he resides. R3 was wandering on the hallway, stopping at various doors but did not enter. R3 was alert to self only.R3's Face Sheet, undated, documents R3 has the following diagnoses: Dementia, Restless and Agitation, Unspecified Psychosis, Major Depressive Disorder, Generalized Anxiety Disorder, and Insomnia.R3's Minimum Data Set, MDS, dated [DATE], documents R3 has a BIMS (Brief Interview of Mental Status) score of 2, indicating R3 has severe cognitive impairment.R3's Care Plan, with a review date of 7/22/25, documents R2 is exhibiting wandering behaviors and is at risk for injury related to impaired safety awareness. He invades other's spaces without intention, gets confused where his room is. Interventions include: approach resident in a calm manner and to calmly que and redirect. R3's Progress Note, dated 4/4/2025 at 2:17 AM, documents the following: Resident very confused. Wants to go back home, goes in others' rooms, got into verbal fight with (previous resident) in room [ROOM NUMBER] because (R3) kept going into the (previous resident's) room. Got into room [ROOM NUMBER], refused to get out of the female resident's room. Hit CNA (Certified Nursing Assistant), kicked me, the nurse. Together 3 CNAs got him into his room. Will keep monitoring.R3's Progress Note, dated 4/4/2025 at 5:13 AM, documents the following: Slept for 90 minutes, still going into other rooms, up and down, monitored behavior.R3's Progress Note, dated 4/7/2025 at 2:39 AM, documents the following: CNA informed this nurse (R3) wandered in another resident room and was attacked by resident. This nurse went in to check on (R3) and he was lying in bed, c/o (complaining of) back and neck pain. This nurse observed bruising and lacerations on his upper back and showers (shoulders). Resident AOx1 (Alert and Oriented to Self) and not able to describe what happened. Resident sent to (local hospital) for evaluation. Bed hold policy and all appropriate documents sent with resident.POA (Power of Attorney) called and informed of incident. MD (Medical Doctor) made aware.R3's Hospital AVS (After Visit Summary), dated 4/7/25, documents R3 was seen in the emergency room due to being an assault victim. R3's Abuse Investigation Final Report, dated 4/7/25, documents the following: A resident-to-resident altercation was reported to the Administrator that took place to between residents R3 and R8 (Former Resident). It was reported that R8 stormed R3 due to him trying to get into his (R8's) room. R8 was seen hitting, kicking, and scratching, R3 with scissors. The residents were immediately separated. R3 was assessed and was found to have scratches and was sent to the local emergency room for further assessment and treatment. He returned the same day with NNO's (no new orders). The scissors were taken from R8, and he was sent to the local hospital for a psychiatric evaluation. Upon his admission to the hospital, he was given an emergency discharge from the facility. R8's state guardian was notified of the decision. The facility MD (medical doctor), POA's, and local police were notified.R3's Psychiatry Initial Evaluation Note, dated 4/17/2025 at 12:09 PM, documents the following: Chief Complaint: Initial Assessment. History of Present Illness: 71 y/o (Year Old) Male with Dementia and Agitation. History obtained from patient and staff. Patient pleasant and cooperative with assessment with intermittent confusion. Patient was recently involved in an altercation due to his wandering behaviors, where he was assaulted by another elderly dementia patient for wandering into his room. Patient was not seriously injured, treated and readmitted after being sent to the hospital. Patient can be difficult to redirect, and staff report he can then become easily agitated. Pleasant at time of assessment with some confusion and nonsensical talk. Patient diagnosed with Alzheimer's Disease, psychosis, dementia, GAD (Generalized Anxiety Disorder), MDD (Major Depressive R3's Progress Note dated, 7/17/2025 at 9:40 AM, documents the following: The Identified Offender was assessed using the Identified Offender Risk Assessment and scored a 9, indicating a compromised risk level. The resident continually exhibits significant cognitive impairment and consistent disorientation related to a diagnosis of dementia. The resident has a documented history of behavioral disturbances, including verbal aggression and sexually inappropriate behavior directed toward staff and other residents. The resident also has been known to frequently display wandering and rummaging behaviors. It has been highly recommended that ongoing monitoring and implementation of appropriate interventions should be continued to maintain the safety and well-being of all individuals within the facility.On 8/13/25 at 9:25 AM, V1, Administrator, stated he was not employed by the facility when the altercation between R3 and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to adequately assess and provide supervision to prevent elopement for 1 of 5 residents (R7) reviewed for supervision in the sample of 8.Findings Include:On 8/13/25 at 11:00AM, R7 observed up in his electric wheelchair exiting the facility through the front door. R7 was able to enter the code and stayed in front of the facility.R7's Face Sheet, undated, documents R7 has the following diagnoses: Hemiplegia and Hemiparesis following a Cerebrovascular Disease Affecting the Left Non-Dominant Side, Cerebral Infarction, Vascular Dementia, and Acquired Absence Below the Knee of Right and Left Legs.R7's Minimum Data Set, MDS, dated [DATE], documents R7 has a BIMS (Brief Interview of Mental Status) score of 12, indicating R7 has moderate cognitive impairment.R7's Care Plan, dated 1/27/23, documents R7 is limited in physical mobility R/T hemiplegia and amputation. R7 utilizes an electric w/c (wheelchair). R7's electric w/c seat belt damaged.R7's Care Plan, dated 7/18/25, documents R7 is limited in physical mobility R/T (Related To) bilateral amputation, chair bound, and hemiplegia.R7's Care Plan, dated 8/12/25, documents R7 is at risk for falls CVA (Cerebrovascular Accident) with left side hemiparesis, CAD (Coronary Artery Disease), MI (Myocardial Infarction), HTN (Hypertension), NIDDM (Non-Insulin Dependent Diabetes Mellitus), DJD (Degenerative Joint Disease), Depression and Debility secondary to CVA. R7's Progress Note, dated 7/5/2025 at 5:01 PM, documents the following: A visitor notified writer of resident being outside leaning over in wheelchair and unable to get back in the building. Staff went to assist resident and reminded resident that he is not an independent smoker and that he is supposed to follow facilities supervised smoking times due to safety concerns. Resident verbalized understanding and continued to go outside multiple times alone throughout the day.R7's Progress Note, dated 7/8/2025 at 7:20 PM, documents the following: Resident was once again outside in the front smoking, reminded him again that he is not an independent smoker and that he is supposed to follow facilities supervised smoking times due to safety concerns. Resident was upset and asked to be left alone. He continues to knowingly break smoking policy often.R7's Progress Note, dated 8/2/2025 at 5:50 PM, documents the following: Resident had fall in grassy area. Offered ER (Emergency Room) r/t fall; resident refused. Resident was educated on risks of leaving facility unattended, verbalized understanding - stated he needed cigarettes. MD (Medical Doctor) made aware. Attempted to notify POA (Power of Attorney) twice with no answer.R7's progress note, dated 8/2/2025 at 6:12 PM, documents the following: Intervention for fall-educated to remain on safe pathways around facility entrances and to not attempt to leave the facility in his chair alone.On 8/13/25 at 8:41 AM, R7 was observed in bed, eating breakfast. R7 has had both feet amputated. R7 is alert and oriented to person, place, time, and situation. R7 stated he was in his electric wheelchair and went down the hill at a decent speed, on the grass, and hit tire tracks in the grass and the whole chair flipped over his head. R7 stated his right leg had scratches from it. R7 stated he left the facility to go get cigarettes at the gas station. R7 states a black man and a white women stopped to help get him back in his wheelchair. R7 stated he then went back to the facility by himself and told staff what happened. R7 stated if he did make it down the street, he would have crossed by an open opportunity and crossed the street to get to the gas station. The road R7 is referring to is a busy 2 lane road with a center turn lane, at the end of the street, there is a stop light and pedestrian cross walk directly across from the gas station R7 was attempting to go to. R7 states he was pretty close to the road when he fell out of his wheelchair. R7 stated he was scared and could have been killed. R7 stated he did not tell anyone he was leaving the facility and stated, Why would I, I've done it before? R7 stated he is allowed to leave the facility by himself, but no one knew he left. R7 stated H*** No, he would never do this again. R7 stated his wheelchair is working fine. R7 stated did go to the hospital after the incident. R7's Progress Note, dated 8/2/2025 at 9:04 PM, documents the following: Resident allowed skin assessment once in bed. Resident has open areas noted to bilateral legs and left elbow. Areas cleansed with dressings applied. Wound care team made aware. Spoke with POA about incident and POA stated he will speak with resident about leaving facility unattended.R7's Progress Note, dated 8/4/2025 at 5:29 PM, documents the following: Fall f/u (Follow Up) day 2, resident c/o (complains of) pain to bilateral legs/back/bottom, x-rays completed to legs, no fractures noted. MD made aware of increased pain r/t fall, new order for Norco PRN (as needed), order entered, script received by pharmacy.R7's Progress Note, dated 8/5/2025 at 3:09 PM, documents the following: Resident requested ER (Emergency Room), stated he wanted to get checked out r/t previous fall. Sent to local ER for further evaluation. MD notified. Attempted to

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide revise interventions/approaches for behaviors in a resident with Dementia related to wandering for 1 of 1 resident (R3), reviewed for Dementia Care in the sample of 8.Findings include:On 8/13/25 at 1:00PM, R3 was observed ambulating independently on the hallway he resides. R3 was wandering on the hallway, stopping at various doors but did not enter. R3 is alert to self only.R3's Face Sheet, undated, documents R3 has the following diagnoses: Dementia, Restless and Agitation, Unspecified Psychosis, Major Depressive Disorder, Generalized Anxiety Disorder, and Insomnia.R3's Minimum Data Set, MDS, dated [DATE], documents R3 has a BIMS (Brief Interview of Mental Status) score of 2, indicating R3 has severe cognitive impairment.R3's Care Plan, with a review date of 7/22/25, documents R3 is exhibiting wandering behaviors and is at risk for injury related to impaired safety awareness. He invades other's spaces without intention, gets confused where his room is. Interventions include: approach resident in a calm manner and to calmly que and redirect. There were no revised or added resident centered interventions since 4/20/25 on the care plan.R3's Progress Note, dated 4/4/2025 at 2:17 AM, documents the following: Resident very confused. Wants to go back home, goes in others' rooms, got into verbal fight with (previous resident) in room [ROOM NUMBER] because (R3) kept going into the (previous resident's) room. Got into room [ROOM NUMBER], refused to get out of the female resident's room. Hit CNA (Certified Nursing Assistant), kicked me, the nurse. Together 3 CNAs got him into his room. Will keep monitoring.R3's Progress Note, dated 4/4/2025 at 5:13 AM, documents the following: Slept for 90 minutes, still going into other rooms, up and down, monitored behavior.R3's Progress Note, dated 4/7/2025 at 2:39 AM, documents the following: CNA informed this nurse (R3) wandered in another resident room and was attacked by resident. This nurse went in to check on (R3) and he was laying in bed, c/o (complaining of) back and neck pain. This nurse observed bruising and lacerations on his upper back and showers (shoulders). Resident AOx1 (Alert and Oriented to Self) and not able to describe what happened. Resident sent to (local hospital) for evaluation. Bed hold policy and all appropriate documents sent with resident.POA (Power of Attorney) called and informed of incident. MD (Medical Doctor) made aware.R3's Progress Note, dated, 4/07/2025 at 6:32 AM, documents the following: Resident returned to facility. NNO (No New Orders) staff will continue to monitor. No signs of distress. No c/o pain or discomfort.R3's Progress Note, dated 4/13/2025 at 7:40 AM, documents the following: Resident was seen by staff sitting on the sides of several residents' beds and was getting aggressive towards staff when asked to get out of their rooms. Resident was given PRN (As Needed) pain and anxiety medication with no results. EMS (Emergency Medical Services) were called and R2 was sent to (local hospital) for further psychiatric evaluation.R3's Progress Note, dated 4/14/2025 at 1:30 AM, documents the following: Resident had some behaviors this shift going in other resident's room. With a lot of redirecting resident finally resting in room, call light within reach. NO (New Order) from MD to increase the dose of following medications: Citalopram 20 mg (milligram) po (by mouth) daily and Rexulti 1 mg (milligram) po (by mouth) daily.R3's Psychiatry Initial Evaluation Note, dated 4/17/2025 at 12:09 PM, documents the following: Chief Complaint: Initial Assessment. History of Present Illness: 71 y/o (Year Old) Male With Dementia and Agitation. History obtained from patient and staff. Patient pleasant and cooperative with assessment with intermittent confusion. Patient was recently involved in an altercation due to his wandering behaviors, where he was assaulted by another elderly dementia patient for wandering into his room. Patient was not seriously injured, treated and readmitted after being sent to the hospital. Patient can be difficult to redirect, and staff report he can then become easily agitated. Pleasant at time of assessment with some confusion and nonsensical talk. Patient diagnosed with Alzheimer's Disease, psychosis, dementia, GAD (Generalized Anxiety Disorder), MDD (Major Depressive Disorder), insomnia, and history of alcohol dependence.R3's Progress Note dated, 4/16/2025 at 7:09 AM, documents the following: Resident had some behaviors this shift going in other resident's room. With a lot of redirecting resident finally resting in room, call light within reach.R3's Progress Note dated 4/16/2025 at 6:03 PM, documents the following: Resident continues behaviors, so I spoke with the doctor today, New Order for Zyprexa 2.5mg daily PRN and recently was placed on Rexulti 1mg, Doctor stated he will have to place the resident on these meds first before he changes medications. Resident resting in chair and cont. (continue) to monitor. R3's Progress Note, dated 4/19/2025 at 6:07 PM, documents the following: This resident continue to go into another resident's room, resident was redirected and will cont. to monitor R3's Progress Note, dated