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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 09/12/2025 |
| 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) | | |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent resident to resident abuse in 1 of 3 residents (R9) reviewed for abuse in a sample of 3. Findings Include: R9's Face Sheet, undated, documents R9 was admitted to the facility on [DATE] and has a medical diagnosis of Psychoactive Substance Abuse, Blindness Right Eye Category 3, Blindness Left Eye Category 3, and Hallucinations. R9's Minimum Data Set (MDS) dated [DATE] documents R9 is moderately cognitively impaired and has displayed verbal behaviors directed towards others. R9's Care Plan R9's Care Plan Last Reviewed/ Revised 8/18/2025 documents resident is considered at risk for abuse/neglect. R9's Progress Note dated 9/8/2025 at 6:05 PM documents This resident had an altercation with another resident related to resident hitting him in the groin. Then resident started slapping other resident in the face. No injury noted Admin and Director of Nursing (DON) made aware and police was call. Stated to keep everyone separated. The Facility's Initial Serious Injury Incident and Communicable Disease Report dated 9/8/2025 documents the following: Resident to Resident Immediately separated. Administrator notified. Final to follow. On 9/11/2025 at 1:50 PM V1, Administrator, stated he got a call Monday 9/8/2025 evening that there was an incident with R9 and R10. V1 stated R9 was outside of the facility with another resident when an argument occurred and R9 made contact with R10. V1 stated nursing staff separated the residents and both were assessed. On 9/11/2025 at 1:55 PM V7, Licensed Practical Nurse (LPN) stated V22, Certified Nursing Assistant (CNA) came to her and stated that she saw R9 hit R10 and herself and V22 went outside of the facility to separate the residents and assess each resident. On 9/11/2025 at 2:05 PM V25, LPN, stated she was informed by nursing staff that R9 had hit R10. V25 stated she went outside of the facility with V7 to access R9 and R10. On 9/11/2025 at 2:24 PM R9 stated he was outside with R8 when R10 started arguing with them. R9 stated R10 hit him in his private area and R9 smacked R10 back. On 9/11/2025 at 3:16 PM V22, CNA, stated she was in a resident room passing a food tray when she saw R9 smack R10 through the room window. V22 stated she told V7 what she has seen, and they went outside along with V25 to separate the residents. The Facility's Abuse Prevention Policy, Revision Date 9/29/2022, documents This facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and resident secure environment.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 145241 |
| | | If continuation sheet Page 1 of 1 |