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	03/26/2026

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. Based on interview and record review, the facility failed to notify a resident's representative and physician of a change in condition in 1 of 3 residents (R7), reviewed for notifications of changes in the sample of 3.Findings Include:On 3/24/26 at 9:20 AM, V7, R7's Family, stated after R7 passed away they received a bill from a wound care company that had seen R7 for a wound and something was removed, the family was not notified of any wounds and didn't know about it until they received a bill. V7 stated they did not notify the family that R7 had been removing her tracheostomy tube, and the communication was horrible. R7's Face Sheet, undated, documents R7 had the following diagnoses: Intracerebral Hemorrhage, Anxiety Disorder, Unspecified Dementia, Tracheostomy Status, Acute Respiratory Failure, and Depression. V7 is listed as R7's emergency contact and power of attorney.R7's MDS (Minimum Data Set), dated 9/28/25, R7 had a BIMS (Brief Interview of Mental Status) score of 00, indicating R7 had severe cognitive impairment. R7 utilizes a tracheostomy with ventilatory support.R7's Care Plan, dated 9/24/25, documents R7 is at risk for respiratory difficulties related to respiratory failure with an intervention to notify her physician of any changes.R7's Progress Note, dated 9/27/25 at 9:17 AM, documents the following: Resident decannulated herself. RT (Respiratory Therapy) attempted three times to replace trach. Resident's stoma closed quickly. Stoma care provided and resident placed on 3 lpm nasal cannula. Resident's cough is strong, and saturation levels are wnl. Will continue to monitor.On 3/24/26 at 9:00 AM, V2, DON (Director of Nurses) stated R7 was a resident at the facility for about two weeks. V2 stated R7 did have a history of removing her tracheostomy tube. V2 was not sure if R7's family or physician was notified of any changes. On 3/26/26 at 12:10 PM, V3, ADON (Assistant Director of Nurses) and V30, MDS/Care Plan Coordinator, stated they were unsure if R7's family was notified of any changes in condition. On 3/26/26 at 12:15 PM, V15, LPN (Licensed Practical Nurse), stated she is not familiar with R7, however does notify the residents families with any changes in condition.On 3/26/26 at 12:25 PM, V26, LPN, stated R7 did have a history of pulling at her tracheostomy tube, the feeding tube, and anything within her reach. V26 stated after R7 extubated herself and was placed on oxygen she was moved to the 200 hallway and that is where she (V26) took care of her. V26 stated she always notified R7's family and physician of any changes. The Change in a Resident's Condition or Status Policy, dated 11/2016, documents the facility must immediately inform the resident, consult with the resident's physician, and notify, consisitent with his or her authority, the resident representative when there is any changes in the level of care, resident rights, etc. Unless otherwise instructed by the resident, the nurse supervisor/charge nurse will immediately notify the resident's family or representative anytime there is a significant change in the resident's physical, mental or psychosocial status.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement preventative measures for a resident with a known history of attempting self extubation of the tracheostomy tube in 1 of 3 residents (R7), reviewed for respiratory/tracheostomy care in the sample of 13.Findings Include: On 3/24/26 at 9:20 AM, V7, R7's Family, stated R7 was admitted to the facility from another state, it was a disaster from when she was admitted until she passed away. R7 pulled out her tracheostomy tube on several occasions. V7 stated they did not notify the family that R7 had been removing her tracheostomy tube, and the communication was horrible. R7's Face Sheet, undated, documents R7 had the following diagnoses: Intracerebral Hemorrhage, Anxiety Disorder, Unspecified Dementia, Tracheostomy Status, Acute Respiratory Failure, and Depression. R7 was admitted to the facility on [DATE].R7's MDS (Minimum Data Set), dated 9/28/25, documents R7 had a BIMS (Brief Interview of Mental Status) score of 00, indicating R7 had severe cognitive impairment. R7 had little interest or pleasure in doing things, exhibited verbal behaviors directed towards others, had a tracheostomy with ventilatory support provided. R7's Care Plan, dated 9/23/25, documents R7 is experiencing episodes of anxiety and is at risk for respiratory complications related to respiratory failure. There were no documented interventions in R7's records to indicate the facility implemented preventative measures/interventions for R7 pulling out her tracheostomy tube. R7's POS (Physician Order Sheet) documents an order dated 9/23/25, documents R7 is to utilize a size 7 tracheostomy tube. R7's Progress Note, dated 9/23/25 at 6:14 PM, documents the following: 84 y/o (year old) female resident arrived at the facility via EMTs (Emergency Medical Technicians) at 6:00 PM from an outside hospital. Resident previously had a stroke r/t (related to) a flaccid left sided weakness with minimum ROM (Range of Motion). Mild edema to LUE (Left Upper Extremity). Small bruising on right anterior forearm, Skin dry. 2 second capillary refill. Resident has small skin tear on ride side of chest per skin assessment. Lung sounds clear upon auscultation. Dry dressing placed. Alert and orient x4 and can make needs known per nurses' report. Incontinent of BB (Bowel and Bladder). ABD (Abdomen) soft, non-tender. Last bowel movement 9/22/25. VS (Vital Signs) 111/75, 70, 18, 98% ON 4L O2 (Liters of Oxygen). Gastrostomy tube in place. Tube-feeding patent and running per order. Resident uses her right hand to grab at things, like to pull at trash and gastrostomy tube per report. Hx (History) of hypertension, atrial fibrillation, and type 2 diabetes. All orders put in and MD (Medical Doctor) notified.R7's Progress Note, dated 9/23/25 at 9:50 PM, documents the following: (R7) has pulled off her trach collar times 3, saturations are 96%. RT (Respiratory Therapy) will continue to monitor.R7's Progress Note, dated 9/24/25 at 7:26 AM, documents the following: Resident remains on new admit day 1. resident is A&O (Alert and Oriented) x3. resident has a left sided weakness r/t right sided stroke. resident is trached not vented. lung sounds clear. Incontinent of B&B. active bowel sounds in all 4 quads. abdomen soft and non- tender. G-tube (Gastrostomy Tube) intact and patent. resident extremely restless. resident having to be repositioned multiple times. resident tried multiple times to remove vent mask. resident gave herself 2 skin tears on her upper right chest. both areas are 3x1. Both areas have been cleaned, and dry dressing have been applied. MD and POA (Power of Attorney) have been made aware. Wound nurse has been made aware, and she will be seen by wound doctor upon next visit. resident is currently resting quietly with call light in reach.R7's Progress Note, dated 9/24/25 at 9:20 AM, documents the following: Resident has pulled herself off of trach collar four times this morning. She has also emptied humidity water bottle x2. O2 tank and water bottle moved to foot of bed to avoid spilling. Will continue to monitor resident. O2 saturation has stayed in the mid 90's.R7's Progress Note, dated 9/27/25 at 9:17 AM, documents the following: Resident decannulated herself. RT attempted three times to replace trach. Resident's stoma closed quickly. Stoma care provided and resident placed on 3 lpm nasal cannula. Resident's cough is strong, and saturation levels are wnl (within normal limits). Will continue to monitor.R7's Progress Note, dated 9/29/25 at 7:37 AM, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documents the following: Resident is A&Ox3. resident has a left sided weakness r/t right sided stroke. resident is decannulated and on 3 L of O2 NC (Nasal Cannula). resident continues to take NC off and leaving it off. resident continues to maintain an O2 SAT (Saturation) of 93-96% while NC is off. incontinent of B&B. active bowel sounds in all 4 quads. abdomen soft and non- tender. G-tube intact and patent. resident extremely restless. resident having to be repositioned multiple times. resident treatment to chest completed resident tolerated well. resident is currently resting quietly with call light in reach.R7's Progress Note, dated 10/01/25 at 12:44 AM, documents the following: (R7) removed her nasal cannula X2, her saturations were 90%. RT put 1 liter NC on her and her saturation went up to 99%. RT will continue to monitor.On 3/24/26 at 9:00 AM, V2, DON (Director of Nurses) V2 stated R7 was a resident at the facility for about two weeks and passed away. V2 stated R7 did have a history of removing her tracheostomy tube. On 3/26/26 at 12:10 PM, V30, MDS/Care Plan Coordinator, stated R7 extubated herself, he isn't sure if she had a history of doing this or if there were any preventative measures in place. On 3/26/26 at 12:25 PM, V26, LPN (Licensed Practical Nurse), stated R7 did have a history of pulling at her tracheostomy tube, the feeding tube, and anything within her reach. V26 stated R7 was very anxious and they got her on some medications and after a while, they did help to calm her down. V26 stated as preventative measures, they placed an abdominal binder over R7's g-tube site and kept other items out of her reach. V26 stated with R7's tracheostomy tube, there wasn't anything they could do to keep her from pulling at it and it was inevitable that she was going to pull it out. The Problematic Behavior Management Clinical Protocol Policy, dated 2/2012, documents the staff will use protocols to identify pertinent interventions, other than medications, for the nature and causes of the individual's problematic behavior. The Physician will help identify and authorize appropriate, targeted, and symptomatic treatments. As part of the initial assessment, the staff and physician will identify individuals with a history of impaired cognition, problematic behavior, or mental illness. In addition, the nurse shall assess and document/report whether a resident is a danger to themselves or others.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the Facility failed to store and prepare food in a manner that prevents potential contamination. This has the potential to affect all 94 residents living in the Facility.Findings include: On 3/24/26 at 7:46 AM, V6, Dietary Aid, was plating breakfast from the steam table and was not wearing a hairnet. V6 stated she was wearing a hairnet, but it is clear because the Facility buys clear hairnets. On 3/24/26 at 7:54 AM, in the dry storage room there were several stacks of boxes all over the floor that included three boxes of bread, two boxes of brown sugar, a box of dry cereal, a box of apple juice, a box of potato chips, a box of jelly, a box of syrup and a box of non-dairy creamer. V4, Dietary Manager, stated the boxes were delivered yesterday and they were short staffed and did not get them put away yet. On 3/24/26 at 11:00 AM, V4 stated the Facility does not buy clear hairnets. The hairnets used in the kitchen have thin black webbing and can be harder to see on dark hair, but are not invisible. On 3/24/26 at 3:30 PM, V1, Administrator, stated he expects all dietary staff to wear hairnets in the kitchen and store food per policy guidelines. The Facility's Cleaning and Sanitation - General Policy revised January 2012 documents the kitchen will be maintained in a clean and sanitary condition, and hairnets or hair coverings will be worn at all times. The Facility's Food and Supply Storage Policy revised January 2012 documents food and supplies will be stored six inches above the floor on clean racks or shelves. The Facility's Daily Census Report dated 3/24/26 documents there are 94 residents living in the Facility.