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	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Southbelt Healthcare	101 South Belt West Belleville, IL 62220

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for hand contracture management and treatment for 1 of 1 resident (R34) reviewed for quality of care in the sample of 57. This failure resulted in R34 experiencing severe pain, infection, and a wound on her left hand. Findings Include: R34's face sheet, print date of 9/23/25, documented R34 has diagnoses including atherosclerotic heart disease, hypothyroidism, type 2 diabetes mellitus, hyperlipidemia, major depressive disorder, anxiety disorder, intermittent asthma, and muscle weakness. R34's MDS (Minimum Data Set), dated 7/4/25, documented R34 is moderately cognitively impaired. R34's care plan, undated, documented resident has contractures of the right hand with interventions of ensure proper positioning as tolerated in bed and chair, meds as ordered and observe effectiveness of meds, observe for pain or increased stiffness, and notify MD of changes, provide gentle ROM (range of motion) during daily care as tolerated, and turn and reposition as needed while in bed/chair. R34's progress note, dated 9/15/25 at 2:10 AM, documented resident requested to go to hospital r/t pain in her left hand, this nurse informed her the wound care doctor would be in, resident stated I fired him, he's insane send me to the hospital please this pain is unbearable. This nurse informed MD. EMS (emergency medical services) currently here to transport resident to (local hospital). R34's local hospital after visit summary, dated 9/15/25, documented reason for visit: finger pain, diagnoses deformity of left hand, injury, finger, left, initial encounter. Instructions: keep fingers apart as much as possible so not injuring each other. R34's care plan was not updated to reflect any interventions to keep R34's fingers apart as much as possible to prevent further injuries. R34's wound evaluation and management summary, dated 9/15/25, documented chief complaint: patient has a wound on her left plantar hand. Etiology: infection. Dressing Treatment Plan: antifungal OTC (over the counter) apply once daily and as needed. Etiology: infection. Duration: more than 3 days. Estimated time to heal: 9-12 months. Wound size (L x W x D): 3.2 x 2.1 x 0.3 cm. Surface area: 6.72 cm. Exudate: Light serous. Dressing treatment plan: antifungal OTC (over the counter) once daily and as needed, silver sulfadiazine once daily and as needed, gauze sponge once daily and as needed. R34's wound evaluation and management summary, dated 9/23/25, documented wound of the left, plantar hand, full thickness. Etiology: infection. Wound size (L x W x D): 3.5 x 2.1 x 0.3 cm. Surface area: 7.35 cm. Exudate: moderate serous. On 9/22/25 at 12:30 PM R34 was observed lying in bed with her left hand tightly contracted. R34's left hand had a foul odor coming from it. R34 did not have any devices in her left hand to reduce pressure between her fingers and the palm of her hand. R34's right hand was not observed to be contracted as documented in R34's care plan. On 09/24/2025 at 3:31 PM R34 stated her left hand hurts all the time and the pain in her hand has gotten worse since she went to the hospital on 9/15/25. A foul odor was noted coming from R34's left hand. On 9/24/25 at 10:45 AM V20 Care Plan Coordinator stated she thought R34's right hand is her contracted hand. V2 DON (Director of Nursing) was present and stated she would go and observe R34's hands to check for contractures. On 9/24/25 at 10:57 AM V2 DON stated she checked R34's hands and it is her left hand that is contracted. V2 stated R34's care plan documented R34's right hand is contracted, and it is R34's left hand that is contracted. On 9/24/25 at 11:00 AM V27 Regional Nurse stated she expects the facility (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 0684 Level of Harm - Actual harm Residents Affected - Few	care plan staff to identify the correct extremities with contractures and implement appropriate interventions for contracture care. Surveyor asked V27 if she expects the facility staff to implement contracture care plan interventions such as hand rolls/hand splints to reduce the risk of residents developing wounds and/or infection and V27 replied yes.The facility's ROM (range of motion)/Contracture Care Policy and Procedure, dated 2011, documented all residents will be assessed on admission and quarterly, or more often as a change of condition warrants, for risk factors for development of contractures. A program will be developed based on the resident's unique risk factors and involving formalized therapy and/or restorative nursing, as applicable. The program will be reflected in the interdisciplinary care plan and will be systematically and consistently followed. Formalized therapy will work closely with nursing staff, as appropriate, communicating and planning for goals and approaches so the team can be consistent in providing the care and services for maintaining joint mobility and for contracture care. It continues, procedure: 1. The nurse will start the functional assessment of new residents by completing the physical function sections of the MDS. 2. When further assessment is triggered for contracture risk or contracture care, further assessment will be done utilizing the designated functional assessment/rehabilitation module to perform further evaluation. 3. A physician's order will be obtained for physical or occupational therapy to evaluate and treat if there is any indication that the resident could benefit by these services. It continues, 8. When a resident has a contracture or contractures already present, formalized therapy will evaluate and work with the nursing department in setting up goals and approaches for the plan of care that specifically addresses this individuals' unique needs. 9. When splints and other contracture devices are part of the plan, formalized therapy will instruct nursing staff as to their use and recommend a schedule for applying and removing the device. 10. Individual plans for preventative ROM (range of motion) and contracture care will be followed as planned seven days a week.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly store medication and label insulin vials. This has the potential to affect all 89 residents residing in the facility.Findings include:On [DATE] at 8:45 AM the facility's 400 Hall medication cart was inspected. The cart contained the following:1. Open and partially used 250-unit multi dose Lispro Pen. The pen documented no name and no open or expiration date. The Lispro pen documents discard after 28 days.2. R60's open and partially used 250-unit multi dose Glargine Pen. The pen documented no open or expiration date.3. R60's open and partially used multi dose Glargine Vial. The vial documented no open or expiration date. The multi dose vial had a label open date, expiration date, initials all blank.4. R11's open and partially used multi dose Lantus vial. The vial documented no open or expiration date. 5. Multiple identifiable loose pills of varying shapes, sizes and color in multiple drawers of the 400-hall medication cart. V28, Licensed Practical Nurse (LPN), opened drawer with 4 rows of medication card. V28 removed a row of cards and counted 200 pills of various shapes and colors loose in the cart in that row. The pills varied in shapes from triangle, circle, oblong, half and whole tablets and capsules. The pills ranged from white, beige, yellow, green, purple, and blue in color. On [DATE] at approximately 9:04 AM V28 stated that she could not identify all the pills loose in the cart or who they belong to. V28 stated that the insulins once open should have an open and expiration date. V28 stated that once open the expiration date is shortened to 28 days. V28 stated that the open and expiration date lets them know when the 28th day is.On [DATE] at approximately 9:10 AM 100 hall back medication cart was inspected. The medication cart contained the following:6. Multiple loose and scattered pills of varying shapes and color in the medication cart.On [DATE] at 9:33 AM Medication Cart for Front 100-Hall inspected. The medication cart contained the following:7. A total of 9 small white pills, a large white pill, a small blue pill, and 3 pink pills loose and scattered at the bottom of the medication drawers.On [DATE] at 9:34 AM V13 stated she could not identify any of the pills or who the pills belong to.On [DATE] at 9:48 AM 500 hall medication cart was inspected. The medication cart contained the following:8. Multiple pills of various shapes, sizes and color loose and scattered throughout the drawers located in the medication cart. On [DATE] at 9:50 AM 300 Hall medication cart was inspected. The medication cart included the following:9. 1 bottle of Oyster Shell Calcium 500mg with use by date [DATE]. No other expiration date was identified on the bottle.On [DATE] at 9:51 AM V9, LPN, stated that the calcium bottle was open, in use and expired. V9 stated that the medication should not be in the cart and should be discarded.On [DATE] at approximately 10:00 AM the 200 Hall medication cart was inspected. The medication cart contained the following:10. Multiple pills of various shapes, sizes and color loose and scattered throughout the drawers located in the medication cart. On [DATE] at approximately 10:12 AM V10, LPN, stated that if she dropped a pill she would get a new one.On [DATE] at 2:02 PM V27, Regional Nurse, stated that the multidose vials and pens are to have an open and expiration date. V27 stated that she expects the nurses to destroy spilled, loose or scattered medications. The facility's Medication Storage policy, dated [DATE], documents that Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. It also documents that Procedures: c. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication and reordered from the pharmacy if a current order exists. It also documents Expiration Dating: C. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, blood sugar testing solutions and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. D2. Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is in a multi-dose injectable vial. E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating (See FORMS: MEDICATIONS WITH SHORTENED EXPIRATION DATES).The CMS dated [DATE] documents 89 people residing in the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation and record reviews the facility failed to serve food that conserved nutritive value, flavor and safe appetizing temperature for 5 out of 5 residents, (R17, R11, R43, R71 and R73); reviewed for Food and Nutrition Services in a sample size of 57.Findings include: R17's Face sheet documented they were admitted to the facility on [DATE]. R17's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact. R11's Face sheet documented they were admitted to the facility on [DATE]. R11's MDS dated [DATE] documented he was cognitively intact. R43's Face sheet documented they were admitted to the facility on [DATE]. R43's MDS dated [DATE] documented he was cognitively intact. R71's Face sheet documented they were admitted to the facility on [DATE]. R71's MDS dated [DATE] documented he was cognitively intact. R73's Face sheet documented they were admitted to the facility on [DATE]. R73's MDS dated [DATE] documented he was moderately cognitively impaired. The facility's Resident Council Meeting Minutes dated 7/21/25 documented the residents had concerns with dietary portion sizes, real fish, soggy fries and menu changes. On 9/22/25 at 9:15 AM, R17 stated the food is sometimes cold when it gets to her and the food could taste better. On 9/23/25 at 2:45 PM, during the Resident Council Meeting, R21, R43, R71, and R73 all stated the food tastes bad, it is cold. R21, R43, R71, and R73 all stated there was reduction in portion sizes and poor quality of food. R21, R43, R71, and R73 stated the food is cold both in dining room and when delivered. On 9/24/2025 at 12:29 PM, Cauliflower was 122 degrees Fahrenheit. The cauliflower was cold and had no flavor, was bland. On 9/25/25 at 12:03 PM V1 Administrator stated he expects the food to taste good and be appropriate temperatures. V1 stated the facility does not have a policy for food palatability.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure clean sanitary conditions in the kitchen, food was labeled, dated correctly, removed from the walk-in refrigerator as indicated, and perform proper hand hygiene during food service. This failure has the potential to affect all the residents who receive food from the kitchen. Findings Include:On 09/22/2025 at 8:50 AM, Initial tour of the kitchen was done. This surveyor washed her hands prior to inspection started and there were no paper towels in the dispenser. The sink where employees wash their hands was dirty. There was dirt and a slimy film and rust around the faucet on the sink. There was a bait trap that had been stepped on lying on the floor by the trash can, the trashcan had dirty marks on the lid, and there was an empty buck that had a hole in the top and there was a pink liquid with dirt on the lid of the bucket. On 09/22/2025 at 8:58 AM, The food storage room was inspected at this time and the following was seen:1. There was a large trash can on wheels that was full (overflowing) of dirty towels and blankets. and there was a white blanket in it. V24, [NAME] threw a dirty rag in the trashcan. On 09/22/2025 9:05 AM The walk-in refrigerator was inspected at this time and the following was seen:2. There was water on the floor immediately to the left of the refrigerator door. There was a towel lying up against the wall in between the wall and the rack holding food. The towel was saturated with water and had brown stains on it. V24, [NAME] said it was from condensation from the freezer next to the refrigerator. 3. Parmesan garlic sauce with the date of 07/05/25 on the lid. 4. Two and a half rolls of uncooked hamburger meat on a tray with blood drainage noted on the tray and the date of 09/16/25. V24 said the date on the tray is the day he took it out of the freezer. 5. Raspberry whipped dessert in a bowl covered with cling wrap with the date of 09/14. V24 took it and threw it away.6. There were two sealed containers of unlabeled fruit (V24 stated it was cantaloup and honeydew melon) both dated 09/08. The honeydew melon appeared to have a slimy film coating the cut-up melon.7. A tray with three grilled cheese sandwiches covered with cling wrap dated 09/18. 8. There was a vegetable tray with a lid, it was dated 09/08 and was unlabeled. In the tray there was pickles, onions, and tomatoes. On 09/22/2025 at 09:15 AM, When going into the walk-in freezer there was water running out of the front and to the left towards the walk-in refrigerator. During noon time meal service, the following was seen: 1. On 09/22/2025 at 11:47 AM, V24, [NAME] had gloves on he took a piece of pork loin to the table next to the stem table, he cut the meat on a cutting board, wiped the knife off then came back to the steam table started to serve the meal with the same gloves on. 2. On 09/22/2025 at 11:49 AM, The timer on the oven behind the steam table went off, V24 went over and turned it off with the same gloves on and then went back to serving food with no hand hygiene or change of gloves done. 3. On 09/22/2025 at 11:56 AM, V24 laid the tongs he had been using to handle the pork loin on the counter of the stem table, then dished up other food with their utensils, when he was done plating the resident's tray, he picked the tongs up off of the counter and placed them back in the pan holding the meat without cleaning/wiping them off. 4. On 09/22/2025 at 11:59 AM, V24 went into the walk-in refrigerator with gloves on and came out with a container that had pickles, onions, and tomatoes in it, he then went back to serving food with the same gloves on with no hand hygiene or change of gloves done. 5. During the meal service V25, Dietary Aide touched dirty counters, dirty carts, and then touched multiple resident food trays without doing any hand hygiene and no gloves were worn during the meal service. On 09/25/25 at 11:43 AM, V26, Dietary Manager stated the food in the walk-in refrigerator if unopened it should have the received date on it, if it is open the food item should have the date received, the open date, and the date to use by. V26 said the container that had the pickles, onions, and tomatoes was their relish plate. She said it is used more often, and when it is empty they are to wash, sanitize, and put a new date on it. V26 said they usually like to always keep at least one roll of hamburger in the refrigerator in case of an emergency. She said they will usually allow three days for thawing of the meat and the meat should be used within three to four (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	days of taking it out of the freezer. V26 said when it comes to handwashing the kitchen staff should be doing it frequently. She said when it comes to the kitchen aide who is putting the food onto the carts as long as they aren't touching the top of the plate then they don't have to wear gloves and if they leave the line for any reason V26 would expect them to wash their hands. V26 said she would expect the cook to wash their hands and change their gloves if they left the food service line and went to the refrigerator to get something. On 09/25/25 at 12:50 PM, V27, Regional Nurse stated she would expect the kitchen staff to keep the kitchen clean and sanitary, she would expect the food to be labeled and dated, and she would expect staff to do hand hygiene. On 09/25/25 at 12:55 PM, V1 Administrator said he would expect the staff in the kitchen to label and date the food, perform hand hygiene, and to make sure the kitchen is clean and sanitary. The facility's food and supply storage policy, revision date of 01/2012, documented Policy: Food and supply storage areas shall be maintained in a clean, safe, and sanitary manner. Procedure: 1. Food services will maintain clean food storage areas. It further documented 4. Prepared foods stored in the refrigerator until service will be covered, labeled, and dated with an expiration date. It also documented 6. All foods will be covered, labeled, and dated. The facility's Handwashing policy, revision date of January 2012, documented Policy: Handwashing facilities will be readily accessible and equipped with paper towels and soap. Staff will wash hands frequently as needed throughout the day following proper handwashing procedure. Procedure: After touching ears, nose, mouth, hair, ect. Any contact with infected or otherwise unsanitary areas of the body. It also documented Hand contact with unclean equipment or work surfaces, hand contact with soiled clothing or other materials that are soiled. Handling raw food or partially cooked meat or poultry.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record reviews the facility failed to perform hand hygiene for 5 out of 5 residents, (R39, R28, R53, R81, R82); reviewed for Infection Control in a sample size of.Findings include:R39's Face sheet documented they were admitted to the facility on [DATE]. R28's Face sheet documented they were admitted to the facility on [DATE].R53's Face sheet documented they were admitted to the facility on [DATE].R81's Face sheet documented they were admitted to the facility on [DATE].R82's Face sheet documented they were admitted to the facility on [DATE].On 9/22/25 at 12:06 PM, V6 (dietary aide), pushed out the resident's meal cart for the main dining room and delivered lunch plates to R39, R28, R53, R81, and R82 without performing hand hygiene prior to serving or in between and after each resident. On 9/24/25 at 1:16 PM, V13 (LPN) stated hand hygiene is supposed to be completed every time a food tray is passed. On 9/24/25 at 1:23 PM, V33 (CNA) stated hand hygiene is supposed to be completed before, in-between and after serving each resident.On 9/24/25 at 2:40 PM, V22 (Nurse Manager) stated hand hygiene is expected to be completed in between each tray by staff. The facility's Safe Food Preparation and Handling policy dated 1/2012 documented hands will be washed properly, frequently, and at appropriate time. Proper handwashing techniques will be used. The facility's Handwashing policy dated 4/2015 documented hands should be thoroughly washed before and after providing resident care. Proper handwashing techniques must be followed at all times. Hand antiseptic/hand sanitizer is a supplement or alternative to the use of soap and water when hands are not visibly solid.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation and record reviews the facility failed to promote respect and dignity for 1 out of 1 residents, (R64); reviewed for in Resident Rights in a sample size of 57.Findings include:R64's Face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, dependence on respirator, encounter for attention to tracheostomy and major depressive disorder.R64's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact and required oxygen therapy, suctioning scheduled and as needed, tracheostomy care, and an invasive mechanical ventilator.R64's Care Plan dated 7/25/25 documented she is risk for respiratory complications with interventions for staff to do the following (all created on 2/6/24): observe for signs and symptoms of pain (grimacing, moaning), provide meds as ordered, provide suctioning as ordered and as needed, respiratory / trach care as ordered.On 9/22/25 at 9:50 AM, R64's room, R64 was coughing in her bed and did not stop coughing, looked up with concern while grimacing, and stated she needed help from staff. This surveyor notified V3, Respiratory Therapist (RT), V4 (RT) and V5 Registered Nurse (RN) at the end of the hall a couple rooms down that she was asking for help while standing in front of R64's doorway. V3 remained sitting and stated oh, she does that all the time. V5 asked R64 if she wanted RT and then told V3 that she needed her while standing in front of R64's doorway. V3 continued to sit and talk with V4 at the end of the hall. On 9/22/25 at 9:53 AM, R64 stated she felt ignored and disrespected by staff as she looked around and waved her hands asking where they were. R64 stated her vent was causing her itchiness and discomfort in her throat and the respiratory treatments help relieve that. On 9/22/25 at 10:00 AM, V3 and V4 continued to sit at end of hall talking after R64 requested help at 9:50 AM.On 9/22/25 at 10:04 AM, V3 and V4 continue to talk at end of hall.On 9/22/25 at 10:09 AM, R64's call light went on and V3 then, went to her door to respond. On 9/24/25 at 1:16 PM, V13 (LPN) stated it should take about 3-5 minutes to respond to a resident asking for assistance or as soon as possible. V13 stated it would absolutely not be acceptable to continue talking to a coworker after being requested by a resident, V13 stated she would absolutely feel ignored and disrespected if she was in that situation as a resident. V13 stated hand hygiene is supposed to be completed every time a food tray is passed. On 9/24/25 at 1:20 PM, V19, Respiratory Therapy (RT) stated it would be acceptable to respond to a resident requesting assistance as soon as she can, sometimes they are in the middle of resident care so as soon as that is completed. V19 stated it is not acceptable for staff not to respond to a resident and continue talking to a coworker instead of checking on them, V19 stated yes of course she would feel ignored or disrespected if she was a resident and that happened to her.On 9/24/25 at 1:23 PM, V33 (CNA) stated responding to a resident's request for assistance should be immediate. V33 stated it would not be acceptable to talk to continue talking to a coworker instead of responding to a resident's request for assistance and she would feel ignored or disrespected if she was a resident and that happened to her. On 9/24/25 at 2:06 PM, V1 (Administrator) stated it is not acceptable for staff not to respond after being requested for assistance at least to assess the situation. The facility's Resident Rights policy dated 8/31/23 documented the resident has the right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility, including: the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Southbelt Healthcare	101 South Belt West Belleville, IL 62220

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for 3 of 7 residents (R34, R44, R76) reviewed for care plans in a sample of 57. Findings include: 1.R34's face sheet, print date of 9/23/25, documented R34 has diagnoses including atherosclerotic heart disease, hypothyroidism, type 2 diabetes mellitus, hyperlipidemia, major depressive disorder, anxiety disorder, intermittent asthma, and muscle weakness. R34's MDS (Minimum Data Set), dated 7/4/25, documented R34 is moderately cognitively impaired and requires assistance with all ADLS (activities of daily living). R34's care plan, undated, documented resident has contractures of the right hand with interventions of ensure proper positioning as tolerated in bed and chair, meds as ordered and observe effectiveness of meds, observe for pain or increased stiffness, and notify MD of changes, provide gentle ROM (range of motion) during daily care as tolerated, and turn and reposition as needed while in bed/chair. R34's progress note, dated 9/15/25 at 2:10 AM, documented resident requested to go to hospital r/t pain in her left hand, this nurse informed her the wound care doctor would be in, resident stated I fired him, he's insane send me to the hospital please this pain is unbearable. This nurse informed MD. EMS (emergency medical services) currently here to transport resident to (local hospital). R34's local hospital after visit summary, dated 9/15/25, documented reason for visit: finger pain, diagnoses deformity of left hand, injury, finger, left, initial encounter. Instructions: keep fingers apart as much as possible so not injuring each other. R34's care plan was not updated to include any interventions to prevent R34's left hand contracture from causing further injuries. R34's care plan does not address R34's left hand contracture at all. R34's wound evaluation and management summary, dated 9/15/25, documented chief complaint: patient has a wound on her left plantar hand. Etiology: infection. Dressing Treatment Plan: antifungal OTC (over the counter) apply once daily and as needed. Etiology: infection. Duration: more than 3 days. Estimated time to heal: 9-12 months. Wound size (L x W x D): 3.2 x 2.1 x 0.3 cm. Surface area: 6.72 cm. Exudate: Light serous. Dressing treatment plan: antifungal OTC (over the counter) once daily and as needed, silver sulfadiazine once daily and as needed, gauze sponge once daily and as needed. R34's wound evaluation and management summary, dated 9/23/25, documented wound of the left, plantar hand, full thickness. Etiology: infection. Wound size (L x W x D): 3.5 x 2.1 x 0.3 cm. Surface area: 7.35 cm. Exudate: moderate serous. On 9/22/25 at 12:30 PM R34 was observed lying in bed with her left hand tightly contracted. R34's left hand had a foul odor coming from it. R34 did not have any devices in her left hand to reduce pressure between her fingers and the palm of her hand. R34's right hand was not observed to be contracted as documented in R34's care plan. On 09/24/2025 at 3:31 PM R34 stated her left hand hurts all the time and the pain in her hand has gotten worse since she went to the hospital on 9/15/25. A foul odor was noted coming from R34's left hand. R34 was noted to be unkempt with greasy hair. R34's point of care completion summary report, dated 8/26/25 - 9/23/25, documented R34's last shower/bed bath was completed on 9/16/25. On 9/22/25 at 12:15 PM V8 CNA (Certified Nurse Assistant) stated R34 refuses to get out of bed for showers. R34's care plan does not address R34's hand wound nor the wound treatment ordered by R34's physician nor does it document an intervention to keep R34's fingers apart as documented on R34's local hospital after visit summary. R34's care plan does not address R34's refusal of hygiene care nor any interventions for R34's refusal of care. 2.R44's face sheet, print date of 9/25/25, documented R44 has diagnoses including COPD (chronic obstructive pulmonary disease), hypertensive heart disease, chronic kidney disease, diabetes mellites, schizoaffective disorder, pre-glaucoma, history of falling, and idiopathic epilepsy with seizures. R44's MDS, dated [DATE], documented R44 is severely cognitively impaired and requires assistance with all ADLS. R44's fall risk assessment, dated 9/10/25, documented R44 was assessed as a high fall risk. R44's progress note, dated 9/15/25 at 2:11 AM, documented (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident rolled from bed to floor mat and crawled back in bed, no injury noted. Intervention for fall - large colored tag placed on side rail to remind resident to lower side rail once in bed. R44's care plan, undated, does not document the fall R44 sustained on 9/15/25 nor does it document an intervention was added to reduce R44's risk of incurring further falls. 3.R76's face sheet, print date of 9/24/25, documented R76 has diagnoses including hemiplegia and hemiparesis following cerebral infarction, anemia, hypertension, unspecified convulsions, dementia, and diaphragmatic hernia. R76's MDS, dated [DATE], documented R76 is severely cognitively impaired and requires assistance with ADLS including eating. R76's weight records, print date of 9/25/25, documented R76 weight on 3/3/25 was 138.4 lbs. and R76's weight on 9/16/25 was 115.2 lbs. R76's progress note, dated 9/22/25 at 6:24 PM, documented the patient's diet has been downgraded to pureed texture with regular liquids due to persistent difficulty at meals masticating advanced textures. Please see SLP (Speech-Language Pathologist) for questions or concerns. R76's care plan, undated, documented R76's weight will remain stable with no loss or gain of 3% or more per month per quarter, diet: 2 gm NA (sodium), low cholesterol, low fat diet with thin liquids. This care plan does not address R76's diet order change to pureed nor does it address R76's 16.67% weight loss since 3/3/25 although R76 has been receiving speech therapy and is being monitored by a Registered Dietitian. On 9/24/25 at 11:05 AM surveyor asked V27 Regional Nurse if she expects facility staff to update care plan interventions with each fall, with weight loss interventions including diet order changes, and with interventions related to residents' non-compliance with care and V27 stated yes. On 09/24/2025 at 10:38 AM V27 Regional Nurse stated the facility does not have a care plan policy and they follow the RAI (Resident Assessment Instrument) manual.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed properly and safely transfer 2 of 5 residents (R45 and R30) reviewed for safety in a sample of 57. This failure resulted in R30's leg being hit on the mechanical lift and experienced pain.Findings include: 1. R45's Care Plan, not dated, does not address R45's transfers. R45's Minimal Data Set (MDS), dated [DATE], documents that R45 has short- and long-term memory problems and is severely cognitively impaired. It also documents that R45 is dependent on staff for bed to chair transfers.R45's Clinical Observation - Transfer Assessment, dated 9/19/25, documents that R45 is to use the full body/Hoyer lift for all transfers.On 9/22/2025 at 10:08 AM observed V29, Certified Nurses Assistant (CNA), and V30, CNA, transfer R45 from the bed to the reclining wheelchair using a full body lift. V29 and V30 applied the sling straps to the lift bar. V30, operating the controls, with V29, standing at the foot of the bed, then raised R45 into the air above bed allowing R45 to swing back and forth without staff contact hitting R45's left leg on the machine bar causing R45 to have facial grimacing, squint eyes, and scowl on face. V29 then grabbed R45's feet. V30 operating the controls started to pull R45 from over the bed. V29 let go of R45's feet. V30, operating the controls with V29, standing on the other side of the wheelchair, then transported R45 across the room to the reclining wheelchair allowing R45 to swing back and forth without staff contact. V29 then leaned over the wheelchair, grabbed the sling, and pulled R45 over the wheelchair. V30 and V29 then lowered R45 into the wheelchair.On 9/25/2025 at 11:08 AM V30 stated that R45 is a full body lift with 2 staff members.On 9/25/2025 at 11:57 AM V37, CNA, stated that R45 transfers with a full body lift and 2 staff. V37 stated that 1 staff operates the machine and the other guides the resident keeping in contact with the resident during the transfer to protect the resident form being hurt.On 9/25/20025 at 12:13 PM V28, Licensed Practical Nurse, stated that R45 is nonverbal and makes uncomfortable faces, grimacing, squinting of eyes and scowling of face that indicate pain. V28 stated that if this occurs R45 is having pain.On 9/25/2025 at 12:15 PM V10, LPN, stated that when a resident is being transferred in the full body lift 2 staff are present and actively participating in the transfer. V10 stated that 1 staff operates the machine and 1 staff guides the resident. V10 stated that a staff member is to be in contact with the resident during the entire transfer.The facility's Safe Patient Handling Program, dated January 2017, documents that Purpose: To identify, assess, and develop strategies to control the risk of injury to residents, nurses and other health care workers associated with lifting, transferring, repositioning, or movement of a resident. This program applies to all staff-assisted resident lifts, transfers and ambulation performed by employees under normal conditions, during the performance of non-routine tasks and in the event of emergencies. Policy Residents identified as Totally Dependent or Extensive Assistance, for example, will be transferred by means of lift equipment and/or other resident assist devices instead of by manual lift. Gait/Transfer belts, including two-handled gait/transfer belts were deemed appropriate, will be used where manual assistance is required for ambulation and transfer activities. Friction reducing devices, such as lift sheets, will be used when repositioning in bed.2. R30's Care Plan, dated 9/15/2025, documents that Resident is a long-term nursing care resident R/T (related to) advanced age, and debility. The resident's inability to independently perform activities of daily living has decreased since admission. Resident needs assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Contributing DX: Heart failure, unspecified; Morbid (severe) obesity due to excess calories; Chronic obstructive pulmonary disease, unspecified.R30's MDS, dated documents that R30 requires Substantial/maximal assistance with transfers.R30's Transfer Assessment, dated 9/19/2025, documents that R45 use gait belt with 2 assists with all transfers.On 9/24/2025 at 9:20 AM V30, CNA, assisted R30 to the bathroom. V30 assisted R30 into the standing position with a count of 3 and grabbed ahold of R30's right arm and assisted R30 into the standing position. V30 then using (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a wheeled walker walked into the bathroom. No staff contact. Upon completion of toileting R30 using a cane and towel bar pulled self into a standing position. V30 then assisted R30 with clothes management. V30 then walked out of bathroom to reclining chair without staff contact.On 9/24/2025 at 9:20 AM V30 stated that R30 was supervision assist with transfers.On 9/25/2025 at 2:02 PM V27, Regional Nurse, stated that she would expect the residents to be transferred properly and safely. On 9/25/2025 at 2:03 PM V2, Director of Nursing, stated that she would expect the residents to be transferred properly and safely. The facility's Gait Belt Use policy, dated July 2014, documents that Policy: It is the policy of [NAME] Healthcare that gait belts will be used when staff are transferring weight bearing residents or assisting them with walking for the safety of the resident or the employee.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to perform complete incontinence care for 1 of 3 (R30) residents reviewed for toileting in a sample of 57.Findings include: R30's Care Plan, dated 3/21/23, documents that Problem: Resident is at risk for impaired skin integrity r/t (related to) incontinent of B&B and decreased mobility. Approach: Provide incontinence care for episodes of incontinence. Resident is incontinent of bowel and bladder and is not appropriate for B&B (bowel and bladder) program due to physical limitations. Approach: Provide incontinent care as neededR30's Minimum Data Set, dated [DATE], documents that R30 is frequently incontinent and dependent on staff for toileting.On 9/24/2025 at 9:20 AM observed V30, Certified Nursing assistant (CNA), provide incontinent care to R30. Observed R30 ambulating to the bathroom with heavily soiled incontinent brief hanging between R30's legs. V30 assisted R30 with removing the heavily soiled incontinent brief and R30 sat on toilet. V30 then wet a towel applied soap and handed the towel to R30. R30 then wiped under her abdominal fold twice. R30 then stood and V30 wiped R30's buttocks. V30 then applied R30's incontinent brief and R30 walked out of the bathroom to the reclining chair. V30 did not cleanse R30's labia, perineum, and thighs.On 9/24/2025 at 9:24 AM V30 stated that R30 cleans her front and the staff clean the back.On 9/25/2025 at 2:02 PM V27, Regional Nurse, stated that she expects all areas of incontinence to be cleaned. The facility's Perineal Care policy, dated July 2017, documents Steps in the Procedure: For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perinea! area, wiping from front to back. (I) Separate labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.) (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (4) Gently dry perineum. c. Instruct or assist the resident to turn on her side with her top leg slightly bent, if able. d. Rinse wash cloth and apply soap or skin cleansing agent. e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia. f. Rinse thoroughly using the same technique as described in e above. g. Dry area thoroughly.