

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/17/2025
NAME OF PROVIDER OR SUPPLIER  Helia Healthcare of Olney		STREET ADDRESS, CITY, STATE, ZIP CODE  410 East Mack Olney, IL 62450	

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 - Minimal harm or potential for 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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure residents were free from abuse for 1 of 3 (R1) residents reviewed for abuse in the sample of 18. This past non-compliance occurred between [DATE] and [DATE]. Findings Include: R1's undated Resident Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses that include dementia with mood disturbances, heart failure, anxiety disorder, Parkinsonism, and localized edema. R1's Minimum Data Set (MDS) dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 07, indicating a moderate cognitive deficit. R1's Care Plan documents a Problem area with a start date of [DATE] of, Category: Behavioral Symptoms, Resident is alert and able to let his needs be known most of the time. He has dx (diagnoses) of depression and anxiety. He has made inappropriate comments to the young staff members, false accusations against staff. likes to get some of the residents stirred up. he will make a fist and threaten them. he also likes to call female resident his girlfriend. 12/3 altercation with another resident. The interventions documented for this Problem area include, Approach start date: [DATE] try to keep this resident away from other resident. R5's undated Resident Face Sheet documents R5 was admitted to the facility on [DATE] with diagnoses that include neuroleptic induced parkinsonism, bipolar disorder, and schizophrenia. R5's MDS dated [DATE] documents a BIMS score of 13, indicating R5 is cognitively intact. R5's Care Plan documents a Problem with a start date of [DATE] of, Category: Behavioral Symptoms, she is alert and able to let her needs known. she has the dx of anxiety, depression. schizophrenia, bipolar, and insomnia. 12/3 manic and hit another resident Klonopin started 12/4 delusions and hallucinations. Labs ordered. This Problem area includes interventions of, Approach Start Date: [DATE] see MAR (Medication Administration Record) for Klonopin assess for effectiveness. A facility Long-Term Care Facility and IID (Individuals with Intellectual Disability)-Serious Injury Incident Report dated [DATE] documents, (R5) (perpetrator) female who is [AGE] years old was in her wheelchair going down the hall when (R1) (victim) 81 was walking back to her (sic) room. (R5) reach out with fist making contact with (R1) side and arm. (R1) then took his fist at (R5) making contact with her arm. Both patients were separated by staff and assessed for any injuries. Skin assessment was performed with no signs of bursing (sic) or red marks. Patient had no other interaction with one another. POA (Power of Attorney), MD (Medical Doctor), and police notified. Care plans updated. No further altercations have occurred with either patient. R1's Progress Notes document on [DATE] at 9:28 AM, CNA (Certified Nursing Assistant) reported to this nurse that resident was hit with a closed fist 4 times by another resident in the torso and arm. CNA stated that resident then grabbed the other resident's arm. Residents assessed for injury and separated. Administrator notified of situation. Called and notified (name of physician). Attempted to notify resident's wife (V4) of situation, no answer, voicemail left to call back. R5's Progress Notes document on [DATE] at 9:13 AM, This nurse was notified by CNA that resident closed fist hit another resident 4 times in the torso and arm. CNA stated that the other resident grabbed her left arm. Both residents were immediately assessed and separated. Administrator notified. Resident is also having hallucinations and made the statement, I wish I could die. Devil come and get me. Called and notified (name of physician). Attempted to notified (sic) POA/daughter (name of POA), no answer. Left voicemail to call back. [DATE] 4:30 PM, (name of physician) office called back with N.O. (new order) Klonopin 0.5 mg (milligrams) BID (twice daily). Called POA/daughter (name of POA) and received verbal consent for medications. [DATE] 12:43 PM, Resident very calm and relaxed today. No behaviors or hallucinations. 15 minute checks continue. R1 is deceased so this surveyor was unable to obtain an interview. This surveyor attempted to interview R5 on [DATE] at 1:25 PM, R5 was unable to recall details of the incident. On [DATE] at 1:56 PM, V4 (Family Member) stated R1 was involved in an altercation with another resident and was hit in the stomach 2-3 times. On [DATE] at 1:39 PM, V3 (Licensed Practical Nurse/LPN) stated the altercation between R1 and R5 was reported to her by V7 (CNA). V3 stated she reported it to V1 (Administrator) and documented it in the residents' medical records. On [DATE] at 2:08 PM, V7 (CNA) stated she reported an altercation she witnessed between R1 and R5 to V3 (LPN). V7 stated after she reported it, she resumed providing care to other residents. On [DATE] at 1:34 PM, V2 (Director of Nurses) stated V7 (CNA) reported an altercation between R1 and R5 to her. V2 stated V7 told her V1 (Administrator) was with the residents. V2 stated she confirmed V1 was with the residents and did not have any direct knowledge of the events after that. On [DATE] at 1:58 PM, V1 (Administrator) stated she didn't witness the altercation between R1 and R5 but it was reported to her. V1 stated V7 (CNA) told her R5</p>		