

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145807	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Helia Healthcare of Newton		STREET ADDRESS, CITY, STATE, ZIP CODE  300 S Scott Street Newton, IL 62448	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on interview and record review, the facility failed to provide twice weekly showers for 3 of 17 dependent residents (R4, R12, R13) reviewed for ADL (Activities of Daily Living) care in the sample of 17.</p> <p>Findings include:</p> <p>1. R4's Face Sheet documented an admitted [DATE] and listed diagnoses including Anxiety Disorder, Hypertension, and Osteoarthritis. R4's Minimum Data Set (MDS) dated [DATE] documented that R4 requires substantial assistance from staff for bathing or showering. March and April 2024 Shower Sheets documented that R4 received showers on 3/2/24, 3/4/24, 4/4/24, 4/8/24, and 4/11/24, with only one shower given on the week of 3/3/24, no showers given on the weeks of 3/10/24, 3/17/24, and 3/24/24, and only one shower given on the week of 3/31/24.</p> <p>On 4/3/24 at 9:55am, R4 was alert and oriented. R4 stated she is to get a shower twice weekly, and she was to have gotten a shower on 4/1/24 but didn't because there was no hot water on the North Hall where she lives. R4 stated nobody offered to take her to get a shower on the South Hall, they just told her she wouldn't be getting one.</p> <p>2. R13's Face Sheet documented an admitted [DATE] and listed diagnoses including Left Femur Fracture with surgical repair following a fall at home. R13's MDS dated [DATE] documented that R13 requires substantial or maximal assistance from staff for bathing or showering. R13's Shower Sheets documented that R13 received showers on 4/8/24, 4/11/24, and 4/15/24, with no showers given on the week of 3/31/24.</p> <p>On 4/3/24 at 10:05am, R13 was alert and oriented. R13 stated she was admitted to the facility on [DATE] and has not had a shower, bath, or bed bath since her admission, nor had any staff asked her if she wanted one.</p> <p>3. R12's Face Sheet documented an admitted [DATE] and listed diagnoses including Congestive Heart Failure, Major Depressive Disorder, and Osteoporosis. R12's MDS dated [DATE] documented that R12 requires substantial or maximal assistance from staff for bathing or showering. March and April 2024 Shower Sheets documented the only showers R12 received during that time were on 3/2/24 and 3/22/24.</p> <p>On 4/11/24 at 12:20 pm, R12 was alert and oriented. R12 stated there have been issues with her not getting twice weekly showers because they are short staffed.</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/4/24 at 3:00pm, V7, Certified Nursing Assistant (CNA), stated staff have problems getting all the showers done due to insufficient CNA staffing. V7 stated residents are to receive a shower or bed bath twice weekly.</p> <p>On 4/10/24 at 3:00pm, V13, CNA, stated residents who are scheduled for showers on the 2:00pm to 10:00pm shift often do not get them due to being short staffed. V13 stated residents receive showers twice a week.</p> <p>On 4/11/24 at 10:25am, V6, Ombudsman, stated R12 had complained to V6 about not getting twice weekly showers.</p> <p>On 4/12/24 at 1:20pm, V1, Administrator, stated there is no problem with residents not getting twice weekly showers but staff may be forgetting to document them.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on interview and record review, the facility failed to safely transfer a resident requiring the use of a mechanical lift for 1 of 4 residents (R13) reviewed for transfers in the sample of 17.</p> <p>Findings include:</p> <p>On 4/4/24 at 12:05pm, V1, Administrator, identified R13 as a resident who requires mechanical lift transfers.</p> <p>R13's Face Sheet documented an admitted [DATE] and listed diagnoses including Cervical Spine Fusion following Wedge Compression Fracture. R13's Minimum Data Set, dated dated dated [DATE] documented that R13 is dependent on 2 or more staff members for transfers. R13's Physical Therapy Evaluation dated 2/7/24 documented, Patient is bed bound and uses (a mechanical lift) for transfers.</p> <p>On 4/10/24 at 3:00pm, V13, Certified Nursing Assistant, stated at times there is only one nurse and one CNA per shift, and that V13 has had to do mechanical lift transfers on residents by herself, which she stated is not policy. V13 stated there have been no negative outcomes associated with these transfers.</p> <p>On 4/11/24 at 12:50pm, R13 was alert and oriented. R13 stated she requires the use of a mechanical lift for transfers. and stated there have been, A few times, that there has only been one staff member doing the transfer. R13 stated there have been no negative outcomes related to these transfers.</p> <p>The facility's Mechanical Lift Policy dated 9/8/23 stated, Policy: The mechanical lift may be used to lift and move a resident with limited ability during transfer while providing safety and security for residents and personnel. The mechanical lift must be able to accommodate the weight of the resident. A sling assessment should be completed to ensure the proper size sling is used for each resident. The facility uses the International Standards Organization guidelines when choosing a sling. Two staff members are required when transferring a resident with a mechanical lift.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on observation, interview, and record review, the facility failed to provide nutritional supplements according to physician's orders for four (R3, R14, R15, R16) of four residents reviewed for nutrition in the sample of 17.</p> <p>Findings include:</p> <p>On 4/2/24 at 11:45am, lunch trayline was observed. Although the diet cards of R3, R14, and R16 specified they were to be served a liquid nutritional supplement, none was sent on their trays.</p> <p>During lunchtime dining observation on 4/3/24 at 11:25am, R3, R15, and R16 did not get supplements on their tray.</p> <p>R3's Face Sheet documented an admitted [DATE] and listed diagnoses including Atherosclerotic Heart Disease and Hypertension. R3's Physicians Orders listed an order for a liquid nutritional supplement at breakfast and lunch.</p> <p>R14's Face Sheet documented an admitted [DATE] and listed diagnoses including Alzheimer's Disease and Hypertension. R14's Physicians Orders listed an order for a liquid nutritional supplement at lunch.</p> <p>R15's Face Sheet documented an admitted [DATE] and listed diagnoses including Huntington's Disease. R15's Physicians Orders documented an order for nutritionally fortified pudding at lunch.</p> <p>R16's Face Sheet documented an admitted [DATE] and listed diagnoses including Arthritis and Hypertension. R16's Physicians Orders documented an order for a liquid nutritional supplement at lunch and dinner.</p> <p>On 4/2/24 at 12:20pm, V5, Dietary Manager, stated the facility received a food order yesterday but they did not get the nutritional supplements they had ordered.</p> <p>On 4/3/24 at 9:20am, R3 was alert and oriented. R3 stated she was not aware she was supposed to be getting a supplement as she has never gotten one.</p> <p>On 4/4/24 at 12:05pm at V1, Administrator, stated staff have the ability to take money out of petty cash and go to the store to buy needed food items such as supplements, and they can also prepare liquid supplements using a recipe.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on interview and record review, the facility failed to provide adequate direct care staffing to meet resident's needs. This has the potential to affect all 36 residents living at the facility.</p> <p>Findings include:</p> <p>On 4/2/24 at 8:40am, V1, Administrator, stated she is the staff member responsible for scheduling nursing staff. V1 stated that for each 8-hour shift, one nurse and two CNA's (Certified Nursing Assistants) are scheduled. V1 stated on Easter Sunday, 3/31/24 the facility experienced, A staffing situation. V1 stated the two CNAs and one nurse scheduled for 6am to 2pm called in sick. V1 stated she called other CNA and nursing staff and everybody refused to come in except V9, Registered Nurse/Minimum Data Set Coordinator, V1 stated V1 worked as a CNA, although she is not certified, and she and V9 had to perform all resident care from 6:00am to 2:00pm until staff came in to relieve them. V1 denied there were any negative outcomes associated with this event.</p> <p>On 4/3/24 at 9:55am, R4 was alert and oriented. R4 stated on Easter morning only V1 and V9 were providing care as none of the other staff had showed up. R4 stated she had to have breakfast in bed, which she did not like, because they did not have time to get her up then, and V1 came in after 8:00am to get her dressed. R4 stated there have been Several times, that there has only been one CNA and one nurse in the building to provide care.</p> <p>On 4/4/24 at 3:00pm, V7, CNA, stated there have been several occasions where he was the only CNA on duty along with one nurse. V7 stated on 3/31/24 he had worked from 6pm on 3/30/24 to 6am 3/31/24. V7 stated staff called in that morning and V1 and V9 had to do all the resident care on day shift. V7 stated staff have problems getting all the showers done due to insufficient CNA staffing.</p> <p>On 4/10/24 at 3pm, V13, CNA, stated she has been in the facility's employ since 10/4/23 via her high school's vocational work program. V13 stated she works from about 3pm to 9pm. V13 stated there are normally two CNAs and one nurse on evening shift, but there have been times where it was just her and one nurse. V13 stated residents who are scheduled for showers on the 2:00pm to 10:00pm shift often do not get them due to being short staffed.</p> <p>On 4/11/24 at 9:50am, V1 stated she has been telling corporate staff that the facility needs more staff, and finally last night at 9pm they gave her the ok to start using a staffing agency again. V1 stated they used one in 2023 but as of January 2024 corporate said they couldn't use them anymore due to budget.</p> <p>On 4/11/24 at 10:25am, V6, Ombudsman, stated residents have complained about the facility being short staffed.</p> <p>On 4/11/24 at 12:20pm, R12 was alert and oriented. R12 stated she is not getting showers twice a week because the facility is short staffed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/3/24 at 10:05am, R13 was alert and oriented. R13 stated she was admitted to the facility on [DATE] and has not had a shower, bath, or bed bath since her admission, nor had any staff asked her if she wanted one.</p> <p>On 4/11/24 at 12:50pm, R2 was alert and oriented. R2 stated there are times when the facility is shorthanded and as a result only one staff member is available to do her mechanical lift transfers.</p> <p>On 4/12/24 at 9:25am, V11, Housekeeping Supervisor, stated she has witnessed occasions where there has been one nurse and one CNA in the building to take care of all the residents.</p> <p>On 4/12/24 at 10:15am, V9 corroborated V1's account of 3/31/24. V9 stated that day was, Horrible. V9 stated thankfully with the holiday, several residents went out with their families and/or had family members come in who fed them. V9 stated there are always holes in the schedule as well as frequent call-ins. V9 stated she and V1 did the best they could and managed to get everything done.</p> <p>On 4/12/24 at 12:35pm, V10, Social Services Designee, stated there are times when one nurse and one CNA are working. V10 stated if corporate staff would let them start using agency staff again, it would not be a problem.</p> <p>The Staff Schedule for March 2024 documented that on the following dates on the 10pm to 6am shift, only one CNA was working with one nurse: 3/8/24, 3/18/24, 3/28/24, 3/30/24. The schedule further documented that 2 CNAs and one nurse called in for the 6am to 2pm shift on 3/31/24 and V1 and V9 worked the floor.</p> <p>A Room Roster dated 4/2/24 documented a total of 36 residents living at the facility.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>32619</p> <p>Based on interview and record review, the facility failed to provide the services of a trained, competent Certified Nursing Assistant (CNA) on 3/31/24. This has the potential to affect all 36 residents living at the facility.</p> <p>Findings include:</p> <p>On 4/2/24 at 8:40am, V1, Administrator, stated on Easter Sunday, 3/31/24 the facility experienced, A staffing situation. V1 stated the two CNAs and one nurse scheduled for 6am to 2pm called in sick. V1 stated she called other CNA and nursing staff and everybody refused to come in except V9, Registered Nurse/Minimum Data Set Coordinator. V1 stated V1 worked as a CNA, although she is not certified as a CAN. V1 stated she and V9 had to perform all resident care duties from 6:00am to 2:00pm. V1 denied there were any negative outcomes associated with this event. V1 acknowledged she performed transfers and incontinence care with no training or experience in personal care. V1 denied feeding residents or assisting with resident medications or treatments.</p> <p>On 4/3/24 at 9:55am, R4 was alert and oriented. R4 stated on Easter morning only V1 and V9 were providing care as none of the other staff had showed up. R4 stated she had to have breakfast in bed, which she did not like, because they did not have time to get her up then, and V1 came in after 8:00am to get her dressed.</p> <p>On 4/4/24 at 3:00pm, V7, CNA, stated on 3/31/24 he had worked from 6pm on 3/30/24 to 6am on 3/31/24. V7 stated CNA staff called in that morning and V1 and V9 had to do all the resident care on day shift.</p> <p>On 4/12/24 at 10:15am, V9 corroborated V1's account of 3/31/24. V9 stated that day was, Horrible. V9 stated thankfully with the holiday, several residents went out with their families and/or had family members come in who fed them. V9 stated she and V1 did the best they could and managed to get everything done and there were no negative outcomes. V9 denied that V1 fed residents or assisted with resident medications or treatments.</p> <p>An undated CNA Job Description stated, The overall purpose of the Certified Nursing Assistant position is to provide each of the assigned residents with routine daily nursing care and services in accordance with the residents' plan of care. Education and experience requirements: State certification as a Certified Nursing Assistant.</p> <p>A Room Roster dated 4/2/24 documented a total of 36 residents living at the facility.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>32619</p> <p>Based on interview and record review, the facility failed to provide the services of a full time Director of Nurses/DON. This has the potential to affect all 36 residents living at the facility.</p> <p>Findings include:</p> <p>On 4/2/24 at 8:40am, V1, Administrator, stated V2, former DON, walked out 3/24/24, giving no notice of termination of employment. V1 stated V2 had stated she was tired of having to frequently work the floor as a nurse in addition to her DON duties. V1 stated there have since been no interested applicants. V1 stated the facility's other nurses, as well as corporate staff, have had to take over some of the DON duties. V1 stated V2 acted as the facility's Infection Control Preventionist and no staff has been assigned to take over those duties. V1 stated V2 is still employed by the facility as a PRN (as needed) staff nurse.</p> <p>On 4/11/24 at 3:30pm, V2 stated she left the position on 3/24/24 because she was tired of not being able to spend time with her family due to her DON duties as well as working the floor when there were call ins. V2 stated she is still employed by the facility PRN as a staff nurse.</p> <p>On 4/12/24 at 10:15a, V9, Registered Nurse/Minimum Data Set Coordinator, stated she is not sure who is performing the DON duties, but it is not her. V9 stated she is performing her own duties as well as having to work the floor at times, and she has no interest in applying for the DON position due to staffing issues.</p> <p>An undated DON Job Description documented, The Director of Nursing will recognize and respond to the nursing and health care of residents. This person will effectively manage the nursing department regarding residents, employees, families' visitors, and the public. The Director of Nursing will make prompt and accurate nursing assessment of care and management judgments. This individual will perform the essential functions of the job in a manner which benefits residents of the facility and complies with business necessity without causing undue hardship. The Director of Nursing position will require an individual who is dependable, self-sufficient, and can easily multi-task. Qualified candidates will plan, organize, develop, and direct the overall operation of the nursing department in accordance with local, state, and federal guidelines and regulations. The position is charged with responsibility to ensure the quality of care is delivered consistently to the resident population; and performs related work as required.</p> <p>A Room Roster dated 4/2/24 documented a total of 36 residents living at the facility.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents are free from significant medication errors for one of four residents (R7) reviewed for medication errors in the sample of 17.</p> <p>Findings include:</p> <p>R7's Face Sheet documented an admitted [DATE] and listed diagnoses including Diabetes Type 2 with Diabetic Neuropathy. R7's April 2024 Physicians Orders documented an order for Humalog U-100 Insulin per sliding scale as follows: If blood sugar is less than 60, call the Physician. If Blood Sugar is 200 to 250, give 2 Units. If Blood Sugar is 251 to 275, give 4 Units. If Blood Sugar is 276 to 300, give 6 Units. If Blood Sugar is 301 to 350, give 8 Units. If Blood Sugar is 351 to 400, give 10 Units. To be given three times daily, dose 1 from 6:00am-10:00am, dose 2 from 11:00am-2:00pm, and dose 3 from 3:00pm-6:00pm. The Physicians Orders also documented an order for Insulin Lispro give 12 units three times daily, dose 1 from 6:00am-10:00am, dose 2 from 11:00am-2:00pm, and dose 3 from 3:00pm-6:00pm</p> <p>On 4/4/24 at from 7:15am to 8:00am, V8, Registered Nurse, was observed passing morning medications for R3, R9, and R10.</p> <p>On 4/4/24 at 10:30am V8 was observed coming out of R7's room and going to the medication cart in the hall. When the Surveyor asked V8 if she was still passing the morning medications, she acknowledged that she was. V8 stated she had had multiple distractions and therefore morning medication pass was late. V8 stated she had just given R7 her Insulin Lispro, which should have been given between 7:00 to 7:30am during breakfast. V8 stated R7's blood glucose level at 6:00am was 172 so R7 had not required and Humalog per sliding scale. When surveyor asked her what her next step was, she stated I guess I'll do her accucheck and go from there.</p> <p>On 4/4/24 at 11:25am, V8 stated she called R7's Physician about the late administration of the insulin, and reported R7's blood glucose at 11:15 was 424. V8 stated the physician ordered her to recheck it in one hour and call back for further instructions.</p> <p>On 4/4/24 at 11:50am, R7 was observed in the dining room eating lunch and was alert and oriented. R7 agreed her morning insulin had been given very late. R7 stated she felt fine and had no negative effects that she was aware of.</p> <p>R7's Medication Administration Record for April 2024 documented the following:</p> <p>4/4/24 Lispro insulin administer 12 units subcutaneously before meals, due at 6:00am to 10:00am. Administered Blood sugar before-172.</p> <p>4/4/24 Lispro insulin administer 12 units subcutaneously before meals, due at 11am to 1pm. Not administered due to late morning administration. Blood sugar before-345.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/4/24 Lispro insulin administer 12 units subcutaneously before meals, due at 3pm-6pm. Administered. Blood sugar before-345.</p> <p>4/5/24 Lispro insulin administer 12 units subcutaneously before meals, due at 6:00am to 10:00am. Administered. Blood sugar before-164.</p> <p>Nursing Progress Notes documented the following:</p> <p>04/04/2024 11:26am. Contacted Physician regarding glucose of 424 related to late administration of morning insulin. Received orders to recheck glucose in one hour and call at time for orders.</p> <p>04/04/2024 12:50pm Glucose 335. Doctor office closed for lunch. Answering service advised to call after 1pm.</p> <p>04/04/2024 02:41pm Technical difficulties reaching Physicians office. Glucose 345 at this time. Will try to reach Clinic at this time.</p> <p>04/04/2024 02:50pm. Contacted with Physician regarding glucose of 345. Orders received to administer scheduled insulin and sliding scale insulin to equal 20 units before supper. Will continue to follow.</p> <p>On 4/11/24 at 9:50am, when asked by the Surveyor to interview V8, V1, Administrator, stated V8 had reported for work that morning to start her shift and had abruptly walked out, thereby terminating her employment.</p> <p>The facility's Administration Procedures for all Medications Policy stated, Policy: To administer medications in a safe and effective manner. Procedures, C: Review the 5 Rights three times.</p> <p>Guidance at The National Institute of Health, <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2957754/#:~:text=Most%20health%20care%20professionals%2C%20especially,standard%20for%20safe%20medication%20practices">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2957754/#:~:text=Most%20health%20care%20professionals%2C%20especially,standard%20for%20safe%20medication%20practices</a>. Defines the 'Five Rights' as the right patient, the right drug, the right time, the right dose, and the right route.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145807	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Helia Healthcare of Newton		STREET ADDRESS, CITY, STATE, ZIP CODE  300 S Scott Street Newton, IL 62448	

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on interview and record review, the facility failed to provide sufficient kitchen staff to carry out nutrition services on [DATE]. This has the ability to affect all 36 residents living at the facility.</p> <p>Findings include:</p> <p>On [DATE] at 9:25am, V1, Administrator, stated the facility's long term Dietary Manager died suddenly on [DATE]. V1 stated her replacement started on [DATE]. V1 stated in addition to the new Dietary Manager, there are two full time cooks, one morning and one afternoon. V1 stated the kitchen is fully staffed based on their census according to their corporation's guidelines. V1 stated on [DATE], Tuesday, one of the cooks called in and the other cook was scheduled to come in at 11:30 and could not come in early, so V1 cooked breakfast that morning. V1 stated she prepared scrambled eggs and provided a choice of cereal as well as donuts, which she stated were not on the menu that day but that combination had been on the menu previously as a Dietician approved meal. V1 stated for lunch she ordered pizza and breadsticks and served chocolate chip cookies which had been the resident choice meal to be served later in the month. V1 stated she checked temperatures of the food for safe holding and serving and documented them according to facility policy, prepared purees according to recipe, and portioned food according to the spreadsheet. V1 stated fluids were provided per resident preference, including thickened liquids following the instructions on the thickener container. V1 acknowledged she did not have certification in food sanitation.</p> <p>The Menu for [DATE] documented that the breakfast meal was to have been choice of cereal, pancakes, scrambled eggs, toast, jelly, margarine,, juice, milk, coffee, and tea. The lunch meal was to have been Mostaccioli, broccoli, garlic toast, and chocolate chip cookie.</p> <p>The Dietary Schedule dated [DATE] documented that the morning cook called out sick and was replaced by V1.</p> <p>An undated Culinary Associate Job Description stated, To be qualified for this position, you must maintain a current Food Services Sanitation certificate and have one (1) year job related experience including food preparation, full-line menu items and therapeutic diets.</p> <p>A Room Roster dated [DATE] documented a total of 36 residents living at the facility.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32619</p> <p>Based on observation, interview, and record review, the facility failed to serve the appropriation portions for a lunch meal according to the menu spreadsheet for four (R3, R9, R13, R14) of eight residents reviewed for nutrition in the sample of 17.</p> <p>Findings include:</p> <p>On 4/2/24 at 11:45am, lunch service trayline was observed. V4, Cook, stated regular trays were to receive a 4 ounce portion of the ham and au gratin potato casserole entree. V4 used a 4 ounce scoop to portion the casserole for R3, R9, R13, and R14's trays.</p> <p>The Menu Spreadsheet for lunch 4/2/24 for regular texture diets called for the service of an 8 ounce ladle of the ham and potato casserole.</p> <p>R3's Face Sheet documented an admitted [DATE] and listed diagnoses including Atherosclerotic Heart Disease and Hypertension. R3's Physicians Orders listed an order for a regular texture diet.</p> <p>R9's Face Sheet documented an admitted [DATE] and listed diagnoses including Hearth Failure and Anxiety Disorder. R9's Physicians Orders listed an order for a regular diet.</p> <p>R13's Face Sheet documented an admitted [DATE] and listed diagnoses including left femur fracture with surgical repair. R13's Physicians Orders listed an order for a regular diet.</p> <p>R14's Face Sheet documented an admitted [DATE] and listed diagnoses including Alzheimer's Disease and Hypertension. R14's Physicians Orders listed an order for a regular diet.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>32619</p> <p>Based on observation, interview, and record review, the facility failed to check the dish machine and surface cleaning agent for the correct proportion of a sanitizing agent, failed to maintain equipment, food contact surfaces and storage areas in a clean and sanitary manner, and failed to store foods to prevent potential contamination. This has the potential to affect all 36 residents living in the facility.</p> <p>Findings include:</p> <p>On 4/2/24 at 11:15am, all cabinets in the kitchen were noted to be covered on the outside with a layer of grime. The floors throughout the area were sticky and had dried food debris around the and under the stove and under prep tables. The steam table held food debris and grime in its empty compartments. All drawers in the kitchen contained food debris. Shelves under prep tables had a thick layer of grime and also food debris. The cooler doors were dirty and grimy with food debris in the bottom. The microwave was dirty inside and out, the turntable had what appeared to be a layer of baked on oatmeal, and there was food debris under the turntable. There was a grimy open bin on one of the prep tables containing a bag of coating mix, a bag of coconut, and a bag of orange drink mix, all open to air. The coconut bag had food debris on it, the drink mix showed signs of having been wet, and there was food debris in the bottom of the bin. There was a layer of grime, grease, and dried food debris on the stove including rotini pasta pieces. There was a thick layer of grime and food debris on top of the dish machine. There was an open bin of plastic silverware under a prep table, and the shelf it was sitting on was grimy.</p> <p>On 4/2/24 at 11:18am, V3, Cook, was observed checking the temperature of ham and potato casserole. V3 picked up a thermometer which was sitting on the wooden prep table without its sheath, and without cleansing the thermometer, placed it in the casserole. Upon removing the thermometer, he wiped it clean using the oven mitt he was wearing and placed it back on the prep table. At 11:25am, he placed the thermometer back into the casserole without cleansing it, and again wiped the thermometer on the oven mitt.</p> <p>On 4/2/24 at 12:55pm, V5, Dietary Manager, was asked by the Surveyor to check the level of sanitizer in the sanitizing bucket which is used for cleaning surfaces. V5 placed a Ph (Potential of Hydrogen) test strip in the water and there was no change in color. The Surveyor asked what that indicated, and what type of chemical is being used for sanitizing surfaces and dishware, and V5 stated she was not sure. The Surveyor then asked for an observation of V5 testing the sanitizer in the dish machine, and V5 stated she was not sure how to do that. V5 stated if there is a kitchen cleaning schedule she does not know where it is.</p> <p>On 4/2/24 at 1:10pm, V3, Cook, stated he was not sure how to check the dish machine or the sanitizer bucket and stated this is not something he does, and nobody has ever trained him how to do it. V3 stated if there is a kitchen cleaning schedule, he is not aware of it.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/4/24 at 10:10am in the dry food storage area, shelving and floors were noted to be covered with a layer of grime. There was a box of powdered sugar, a bag of corn meal, a box of cornstarch, and box of lasagna noodles all being stored open to air.</p> <p>An undated Cleaning and Sanitation Policy stated, The kitchen will be maintained in a clean and sanitary condition. The state and/or federal food code will be maintained on file within the food service department, and will be the basis of all sanitation and food safety practices.</p> <p>An undated Machine Ware Washing Policy documented, Dishes, glassware, cups, utensils, and other dishware are washed, rinsed, and sanitized after each use. The machine for ware washing will be checked prior to each meal period to ensure it is functioning properly. Employees that use the ware washing machine will be responsible for knowing how to use the machine, document its use, and and properly maintain it after use. Steps include: Check that the wash cycle is maintaining proper temperature. Check sanitizer concentration using appropriate test strips.</p> <p>A Room Roster dated 4/2/24 documented a total of 36 residents living at the facility.</p>		