STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145807	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Healthcare of Newton	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)
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 interview and record review the facility failed to ensure wheelchair foot pedals were in place to prevent resident injury for 1 (R4) of 3 residents reviewed for accidents in the sample of 8.This past non-compliance occurred between 3/24/2026 and 3/26/2026.The findings include:R4's Face Sheet documented an admission date of 6/19/2024 with admitting diagnoses including chronic obstructive pulmonary disease, chronic cough, muscle weakness, history of multiple fractures, right patellar tendon rupture and age-related osteoporosis. R4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R4 is cognitively intact. This same MDS documented R4 utilizes a wheelchair for locomotion and does not walk.The facility's Long Term Care Facility-Serious Injury, Incident and Communicable Disease report dated 3/25/2026 documents the following in part: Administrator notified of an x-ray report resulting in an acute non-displaced tibia fracture. According to CNA's (Certified Nursing Assistant) on shift, they were getting (R4) up for breakfast and unknowingly placed her in her roommate's wheelchair. CNA's could not find the foot pedals and R4 suggested they may be in the dining room. CNA's pushed (R4) to the dining room to get foot pedals and (R4) was unable to hold her right foot up. Resident's foot dropped to the floor and her toes bent backwards slightly.Result of xray showed acute non-displaced tibia fracture.On 4/9/2026 at 9:30am, R4 said before she came to the nursing home, she had injured tendons in her right knee that will never really heal up. R4 said due to the old injury, she often has pain in her right knee and takes medications for the pain. R4 said about two weeks ago, the staff (V7 and V8, both CNA's) were getting her up into her wheelchair for breakfast and accidentally put R4 into her roommate's wheelchair which did not have foot pedals. R4 said V8 asked her to hold her feet up off the floor so she could take R4 down to the dining room where staff thought the missing foot pedals were located. R4 said V8 realized R4 was in the wrong wheelchair and turned R4 around in the hallway and headed back to R4's room to get the correct wheelchair. R4 said she couldn't hold her feet up off the floor any longer and her right foot went down and twisted a small bit under the wheelchair. R4 said her right knee had already hurt that morning so she couldn't tell if the pain was from getting twisted or from her previous right knee issues. R4 said afterwards an x-ray of her knee showed a fracture, but she went to the bone doctor, and he said her leg was not broken and the previous x-ray was incorrectly read. R4 said her knee does not hurt anymore and is feeling better. On 4/9/2026 at 11:00am, V8 (CNA) clarified the incident with R4 occurred on the morning of 3/24/2026, and she and V7 (CNA) were getting R4 up for breakfast and accidentally put R4 into her roommate's wheelchair. V8 said R4 kept asking where her foot pedals were and R4 was supposed to have foot pedals on her wheelchair. V8 said she thought the foot pedals were in the dining room but then realized she had R4 in the wrong chair. V8 said when she turned R4 around in the wheelchair to go get the correct wheelchair, R4 dropped her feet and caused her right foot to go under the wheelchair and caused R4 discomfort. V8 said she had R4 evaluated by the nurse and R4 seemed ok.A statement in the facility's investigation file documents V7's account of what happened on 3/24/2026 at approximately 5:45am. The statement documents the following in part: (V7) had assisted R4 to the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathroom and afterwards grabbed the roommate's wheelchair by mistake and put R4 into the wrong wheelchair. (R4) has had many different chairs and I truly didn't notice. (V8) took R4 to the dining room and noticed R4 was in the wrong chair.On 4/9/2026 at 11:30am, V2 (Director of Nursing/DON) said she was the nurse who evaluated R4's right knee afterwards. V2 said R4's doctor and family were notified and an x-ray of R4's right knee/leg was ordered via mobile x-ray unit. V2 said the x-ray results showed R4 had a non-displaced tibia fracture. V2 said R4 went to an Orthopedic follow up appointment on 4/6/2026 and the Orthopedic doctor said R4 did not have a fracture and the mobile x-ray unit read the x-ray incorrectly. V2 said staff knew R4 was supposed to have foot pedals on her chair but didn't realize they were missing. V2 said it was her expectation for R4's wheelchair to have the foot pedals on before R4 uses it.On 4/9/2026 at 10:45am, V9 (Physical Therapist) said she has provided R4's physical therapy for several months and is very familiar with R4's care. V9 said R4 is supposed to have foot pedals when R4 is using the wheelchair. V9 said on 3/12/2026, she in-serviced the nursing staff concerning R4's wheelchair usage and included R4's foot pedals were to be on the chair and elevated.On 4/6/2026 at 10:30am, V10 (Family) said R4 has always been happy with the care at this facility. V10 said she was upset to learn R4 had a fractured right leg due to the staff not using foot pedals when they should have. V10 said she was very happy to hear R4 did not have a fracture, and her right knee was not severely injured during this event.Orthopedic office visit note dated 4/6/2026, documented the following in part: Chief complaint: Right knee tibia fracture. Leg got caught behind wheelchair. No pain reported. At the clinic today for further orthopedic management of tibia fracture, however I do not see any fracture on her most recent x-ray. She is not having any pain.Prior to the survey date, the facility took the following actions to correct the noncompliance:The facility held a QAPI (Quality Assurance and Performance Improvement) meeting on 3/26/2026 with V1 (Administrator) V2 (DON), V11 (Registered Nurse/RN), V12 (RN) and V13 (Regional Administrator). The QAPI Ad Hoc form notes under #1 Immediate corrective action for those affected by the deficient practice: (R4) x-ray showed fx (fracture) to tibia after incident in wheelchair. MD (medical doctor) and emergency contact notified of incident. Report sent to state (agency) Knee immobilizer in place until seen by ortho. Immediate education to staff involved with incident completed 3/26/26.Process/steps to identify others having the potential to be impacted by the same deficient practice: All residents have the potential to be affected.Measures put into place/systematic changes to ensure the deficient practice does not recur: Education to nurses and CNAs on transfers, wheelchair placement and pedals. Ensure all names are on wheelchairs. Ensure therapy communicates new wheelchair placement and pedals with DON/designee. DON/designee to audit (and) ensure proper transport of residents 3x (times)/week for 4 weeks. Consulted NP/MD (Nurse Practitioner/Medical Doctor) on vitamins for strengthen of bone density to prevent further decline.Plan to monitor performance to ensure solutions are sustained: Administrator to ensure programs are being followed. Report findings during QA meetings.