STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146045	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Healthcare of Energy	210 East College Energy, IL 62933

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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interviews, observations, and record review, the facility failed to notify the physician of a resident's change in condition for 1 of 4 residents (R1) reviewed for physician notification of change in condition in a sample of 7. Findings include: R1's Resident Face Sheet documents an admitted [DATE] and was discharged to a local hospital on 12/29/24. R1's Resident Face Sheet documents diagnoses including: Pressure Ulcer of Sacral Region, Hypertension, Anxiety, Asthma, Dementia, and Urinary Tract Infection. R1's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) of 15, indicating that R1 is cognitively intact. On 1/3/2024 at 1:45PM, V5 (Ombudsman) stated she received a call from V6 (Registered Nurse-RN at Local Hospital emergency room) and he reported that R1 was seen in the emergency roiagnom on [DATE] in bad condition. On 1/6/2024 at 1:20PM V6 (RN at Local Hospital emergency room) stated he was working in the emergency roiagnom on [DATE] when R1 arrived by ambulance. V6 stated R1 was not responding and was found to have hypoglycemia with a blood sugar of 35, hypotension, and rectal temperature of 88. degrees Fahrenheit. On 1/8/2025 at 2:33PM, V10 (Certified Nurse Assistant/CNA) stated she took care of R1 on the days she worked. V10 stated she worked dayshift on Wednesdays through Saturdays. V10 stated she had noticed a decline in R1 for the last few weeks before she was sent to the hospital. V10 stated R1 had a foley catheter. V10 stated she had never seen it leak. V10 stated the last few days to a week before R1 was sent to the hospital she noted R1 would only have 25cc (cubic centimeters/ milliliters) of urine output on her shift and R1 would not drink much. V10 stated she would encourage R1 to drink but she would not drink much. V10 stated R1's intake and output had declined and it was reported to the nurses. V10 stated R1 had not lived at the facility long but she did see a decline in her. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/2024 at 6:03PM, V11 (Registered Nurse) stated she took care of R1 on a regular basis. V11 stated R1's appetite was poor, and she mainly ate snacks, and her family brought snacks in all the time. V11 stated most of the time R1's urine output was between 600cc and 700 cc. V11 stated R1's intake and output had been decreasing over the last few days. V11 was asked if the physician was notified and V11 stated I don't remember if I called and notified the physician. On 1/9/2024 at 10:00 AM, V9 (Licensed Practical Nurse) stated she took care of R1 all the time. V9 stated she had seen a decline in R1's condition over the last week prior to R1 going to the hospital and even the day before she sent her out on 12/29/24. V9 stated she couldn't remember if she had notified the physician/Nurse Practitioner about the decline. V9 stated (R1) just wasn't feeling very well for a few days. V9 stated she sent R1 out because she became lethargic. V9 stated I knew she was really sick, so I sent her out. V9 stated I believe I sent a message in (name of physician notification system) after I sent her out but not sure. On 1/10/2024 at 9:06AM, V12 (Physician) stated he saw R1 when she first arrived at the nursing home but R1 has been seen mainly by V13 (Nurse Practitioner). V12 was asked if he was notified on 12/29/2024 or a few days before about R1's change in condition and V12 stated the change in condition and R1 being sent to the hospital did not seem familiar to him. V12 advised this surveyor to call V13 for further information regarding R1. On 1/10/2024 at 11:40AM, V13 stated she was familiar with R1. V13 stated R1 had several medical issues but was surprised she had passed away, but then wasn't surprised after reviewing the emergency room visit notes from 12/29/2024. V13 stated she had seen R1 on 12/19/2024 due to leg edema. V13 stated R1 appeared stable at that time. V13 stated she did not receive any text messages or any messages on (name of physician notification system) prior to, or on, 12/29/2024 regarding R1's change in condition. V13 stated she was on vacation from 12/20/2024 through 12/30/2024. V13 reviewed all of her (name of physician notification system) notes and reported on 12/22/24 that R1 was started on Linzeloid antibiotic for a Urinary Tract Infection and the culture shows the bacteria was susceptible to Linzeloid. V13 stated on 12/16/2024, R1 was started on Doxycycline antibiotics for Pneumonia. V13 stated she had sent R1 out to the emergency room about that time due to R1's oxygen levels being lower than normal. V13 stated there was another Nurse Practitioner (V14) on call for the team during her vacation and provided V14's contact information. V13 stated there were no notes documented in (name of physician notification system) regarding R1's change in condition but would need to validate that with V14. On 1/15/2024 at 1:47PM, V13 stated R1 had many comorbidities which contributed to her illnesses and death. V13 stated R1 had been treated for Pneumonia and a Urinary Tract Infection recently. V13 stated R1 had fluctuations in her [NAME] Blood Cell count frequently. V13 stated the lack of notifications did not contribute to her hospitalization and end of life events. On 1/13/2024 at 11:15AM, V14 (Nurse Practitioner) stated she had not been notified of a change in condition for R1 from the facility prior to R1 being sent to the local hospital on 12/29/2024. V14 stated the facility did notify her of the transfer but that was after the transfer had already happened, V14 stated she was unaware of any change in condition with R1. R1's Lab Reports provided by facility were reviewed for results of Complete Blood Counts and documents R1's WBC (White Blood Cell) count results (with a reference range of 4.0-10.5) as the following: 12/10/24 9. 8, 12/15/2024 13.0, 12/17/2024 16.2, 12/24/2024 19.8, and 12/26/2024 17.4. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress notes were reviewed and there is no documentation noted of MD (Medical Doctor) or NP (Nurse Practitioner) notification of R1's change in condition or reported lab values. R1's Vital Signs flow sheet in the electronic medical record documents the following total urine output for 24 hours for the following dates: 12/23/2024 1,700 milliliters, 12/24/2024 1900 milliliters, 12/25/2024 850 milliliters, 12/26/2024 1110 milliliters, 12/27/2024, R1's 150 milliliters, 12/28/2024 250 milliliters, and 12/29/2024 200 milliliters on night shift. R1's Vital Signs flow sheet also documents the following total oral intake for 24 hours for the following dates: 12/23/2024 300 Milliliters, 12/24/2024 1,000 Milliliters, 12/25/2024 600 Milliliters, 12/26/2024 120 Milliliters, 12/27/2024 120 Milliliters, 12/28/2024 120 Milliliters. There is no documentation for R1's oral intake on 12/29/2024. The facility policy titled Change in Condition revision date of February 2022, documents It is the policy of this facility that resident change in condition will be assessed promptly and follow up activity will occur as appropriate in a timely manner. The section titled Procedure documents 4. The resident's primary physician or designated alternate will be notified immediately of any change in resident's physical or medical condition this includes Accident involving the resident, deterioration in health, mental, or psychological status, need to alter treatment, or a decision to transfer or discharge from facility . 6. Notification of physician and or responsible parties shall be documented in the clinical record as well as on the 24-hour form.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interviews and record review, the facility failed to implement ordered treatments for wound care for 1 of 5 (R1) residents reviewed for pressure ulcers in a sample of 7. The findings include: R1's Resident Face Sheet documents an admitted [DATE] and was discharged to a local hospital on 12/29/24. R1's Resident Face Sheet documents diagnoses including: Pressure Ulcer of Sacral Region, Hypertension, Anxiety, Asthma, Dementia, and Urinary Tract Infection. R1's Minimum Data Set (MDS) dated [DATE] documents a BIMS of 15, indicating R1 is cognitively intact. Section GG documents R1 requires partial/moderate assistance with oral hygiene, toileting hygiene, and shower/bathing self; is dependent for upper body dressing, lower body dressing, putting on/taking off footwear; and requires substantial /maximal assistance with roll left to right. Section I documents under active diagnoses a pressure ulcer of sacral region stage 2. Section M documents R1 has a pressure ulcer/injury, a scar over bony prominence, or non-removable dressing/device and has 1 unhealed Stage 4 pressure ulcer/ injury that was present upon admission/entry or reentry. R1's care plan documents a Problem of Resident is at risk for skin breakdown. Resident was admitted with wound to the coccyx with a start date of 11/4/2024. Documented interventions include: apply TX (treatment) as ordered, consult with wound specialist as needed, assess risk factors, weekly skin assessments, encourage activity, float heels, and special mattress with a start date of 11/4/24. R1's Braden Scale for Predicting Pressure Sore Risk dated 11/5/2024 documents a score of 18 indicating R1 has a mild risk for skin breakdown. R1's Braden Scale for Predicting Pressure Sore Risk dated 12/16/2024 documents a score of 16 indicating R1 has a mild risk for skin breakdown. The Braden Scale for Predicting Pressure Sore Risk documents score interpretation as: 19 or higher= Not at risk, no interventions at this time; 15-18= Mild risk, if other major risk factors are present e.g. (example given), advanced age, fever, poor dietary intake of protein, Diastolic blood pressure 60, hemodynamic advance to next level of risk; 13-14= Moderate risk if other major factors are present advance to next level of risk; 10-12= High risk; and 9 or less=Very high risk. R1's Wound Evaluation and Management Summary dated 11/27/2024 by V4 (Wound Physician) documents that R1 has a Stage 4 Pressure Wound Coccyx, full thickness measuring 5 cm (centimeters) x 5.2 cm x 1.2 cm (length x width x depth) and documents the wound progress as not at goal. This summary documents that surgical excisional debridement procedure was performed to remove necrotic tissue and establish the margins of viable tissue. The dressing treatment plan for the Stage 4 Pressure Wound to the coccyx documents to add Collagen powder once daily for 30 days, Silver Sulfadiazine once daily for 30 days; continue Alginate Calcium once daily for 30 days, gauze roll twice daily for 30 days; and discontinue Sodium Hypochlorite Solution (Dakin's Solution), and gauze sponge. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Wound Evaluation and Management Summary by V4 dated 12/5/2024 documents that R1 has a Stage 4 Pressure Wound Coccyx, full thickness measuring 5 cm x 4.3 cm x 1.2 cm and documents the wound as improved by decrease surface area. This summary documents that surgical excisional debridement procedure was performed to remove necrotic tissue and establish the margins of viable tissue. The dressing treatment plan for the Stage 4 Pressure Wound to the coccyx documents to add Mupirocin Topical 2% once daily for 30 days, continue Alginate Calcium once daily, Collagen Powder once daily, gauze twice daily for 19 days, and discontinue Silver Sulfadiazine. R1's Physician Order Sheet dated 11/1/2024-1/3/2025, documents an order dated 11/6/24 for Dakin's solution 0.5%: topical; special instructions: cleanse the wound to the coccyx with normal saline/wound cleanser; apply Dakin's, gauze sponge, calcium alginate and dry dressing twice a day with a discontinuation date of 12/9/24. R1's Physician Order Sheet does not document the order to add Collagen powder once daily for 30 days, Silver Sulfadiazine once daily for 30 days; continue Alginate Calcium once daily for 30 days, and gauze roll twice daily for 30 days as documented by V4 on the Wound Evaluation and Management Summary dated 11/27/2024 and subsequently does not document to discontinue the Silver Sulfadiazine as documented on the Wound Evaluation and Management Summary dated 12/5/24. R1's Medication Administration Record (MAR) dated 12/1/2024-12/31/2024, does not document any treatment order to R1's Stage 4 Pressure Ulcer to the coccyx since the order for the Dakin's Solution was discontinued on 12/9/24 per R1's Physician Order Sheet. On 1/3/2024 at 2:43PM, V2 (Director of Nursing/DON) stated that residents with wounds are seen by V4 (Wound Physician) weekly. V2 stated wound rounds are made by V3 (Licensed Practical Nurse/LPN). V2 stated V3 takes the orders from V4 (Wound Physician) and processes the orders. V2 stated she expects the nurses to perform the treatments as they are ordered by V4. V2 stated wound reports from V4 include wound assessments, including measurements, and treatments to be done for each resident. V2 stated she has not known of any issues with treatments getting done as ordered. V2 stated there is no ongoing process in place to monitor the completion of treatments. V2 stated treatments are done by the charge nurses. V2 stated R1 had wounds and she was admitted with wounds. V2 stated R1 was being seen by V4. R1's Resident Progress Notes dated 12/29/2024 at 2:52PM documents, This resident was sent to local hospital for evaluation and possible treatment. She has had change in LOC (Level of Consciousness), only alert to herself, edema of plus 3 pitting to her bilateral hips. She is 99% on 4 liters of Oxygen. On 1/6/2024 at 1:20PM, V6 (RN at Local Hospital emergency room) stated he was working in the emergency roiagnom on [DATE] when R1 arrived by ambulance. V6 stated during assessment of R1, R1 had a small dressing on her sacral area with a small 2x2 with some sort of cream and covered with a telfa dressing which did not even cover the wound and had no date on the dressing. V6 stated R1 had multiple lesions noted around the wound to the sacral area. On 1/7/2024 at 10:17AM, V4 (Wound Physician) stated he makes rounds weekly at the facility and assesses wounds. V4 stated he does expect the nurses to process his orders and follow his orders. V4 stated he did see R1 on 12/25/2024. V4 stated as far as he knows R1's dressings were being changed as ordered and he was unaware of anything different. V4 was asked what it meant on his report when the wound progress documents at goal. V4 stated at goal means no change. V4 stated I feel like on the 25th the sacral area (Stage 4) was without change. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/2025 at 10:40AM, V3 (Licensed Practical Nurse/LPN) stated R1's new orders for stage 4 wound to coccyx was not on the December MAR (Medication Administration Record). V3 stated the nurses were doing the same treatment on the Stage 4 wound to the coccyx that was being done on other areas (blisters) to the coccyx and sacral area, which was Bactroban, Clotrimazole, and Maalox, three times a day with dry dressing. R1's December MAR was reviewed with V3. V3 validated that the last dressing order on the MAR for the Stage 4 wound to the coccyx was to cleanse the wound to the coccyx with normal saline/wound cleanser, apply Dakin's, gauze sponge, calcium alginate, and dry dressing twice daily, this order had a discontinued date of 12/9/2024 and no new orders for the stage 4 wound for the remainder of the month. V3 validated there were no orders for treatment to the Stage 4 Coccyx wound on the MAR for December 9th through December 29th. V3 validated the treatments being done by the nurses were not the correct treatments which were ordered by V4. On 1/8/2025 at 2:14 PM, V2 (DON) stated she didn't realize there was a problem with wound orders. V2 stated she was not aware that there were not orders from most of December for the stage 4 wound for R1. V2 stated the orders not being processed or the resident not receiving the ordered treatment failed on different levels. V2 stated she was going to talk with all the nurses about orders and all the wounds in the facility. On 1/8/2024 at 6:03PM, V11 (Registered Nurse/ RN) stated she took care of R1 on a regular basis. V11 stated she remembers doing packing with Dakin's solution to the stage 4 wound to the coccyx, but there were many changes to the orders to her dressing changes. V11 was asked where the treatment orders are found and V11 replied that the orders are always on the MAR and that is where she finds what treatments are supposed to be done. V11 stated she has used Calcium Alginate and Collagen on the stage 4 to the coccyx. V11 stated she believes the last treatment she did for the stage 4 coccyx was the Dakin's solution because it is on the treatment cart, and she believes there was just a new bottle delivered from pharmacy. The facility policy titled Wound Management Program revision date 1/20/2023 documents, It is the policy of this facility to manage resident skin integrity through prevention, assessment, and implementation and evaluation of interventions. Under Procedure it documents Physician Orders should be obtained and followed for each resident.