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	01/31/2025

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

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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** 43088 Based on observation, interview, and record review the facility failed to identify and treat pressure wounds for 3 (R1, R2, and R3) of 4 residents reviewed for pressure wounds in the sample of 6. Findings include: 1. R1's Resident Face Sheet documented an admitted [DATE] with diagnoses including: extradural and subdural abscess, anorexia, dysphasia, generalized epilepsy, non traumatic intracranial hemorrhage, cerebral infarction, benign neoplasm of the meninges. R1's 12/9/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. R1's 12/9/24 MDS section M documented R1 was at risk to develop pressure ulcers/ injuries and R1 had 1 or more unhealed pressure ulcers/ injuries. R1's 12/6/25 Admission Observation documented in part . Alterations in Skin . MASD- Moisture- Associated Skin Damage Describe each skin integrity condition checked in detail . right buttock, redness, and two open areas 1.0 cm long x 0.5 wide . On 1/30/25 at 12:16 PM, V4 (Registered Nurse/ RN) said she completed R1's skin assessment on 12/6/24 when R1 returned from the hospital. V4 said R1 had open wounds to his sacrum and V4 documented it in her assessment. V4 said when a resident has a new wound staff are supposed to take a picture of the wound and upload it into the electronic communication system for the medical providers to give treatment orders. V4 said she did not recall if she had notified the medical provider of R1's new wounds and V4 said she did not know how to upload pictures in the electronic communication system. V4 said she did not recall if she had notified V3 (Wound Nurse/ Licensed Practical Nurse) or V2 (Director of Nursing/ DON) of R1's new wounds. V4 said after she had documented R1's new wounds she had not noticed that no treatments were ordered for R1 during her shifts post discovery. V4 said she did not recall if she had notified R1's family on R1's wounds on 12/6/24 and could not recall if R1's family had asked if R1 had any wounds. On 1/30/25 at 12:16 PM, V3 said she was not notified of R1 having any wounds by any staff until 12/25/25. V3 said prior to V5 (Wound Physician) arriving at the facility every week V3 will speak to the floor nurses to ask if any resident has any new wounds V5 needs to assess. V3 said if the nurses don't tell her of any new wounds the only other way she would be notified was if the nurse made a new event in the resident's Electronic Medical Record (EMR). V3 said no event had been opened on 12/6/24 for R1. V3 said no wound treatments had been completed for R1 until 12/25/24 when he was seen by V5. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 3:10 PM, V5 said he was not made aware of R1's wounds until 12/25/24 when he arrived at the facility to make rounds. V5 said on 12/25/24 R1's wounds were end of life skin failure and the only treatment would be Dakin's solution for odor control. V5 said if he had been notified on 12/6/24 when they were discovered he would have ordered Dakin's Solution but the treatment would not have changed the outcome of R1's wounds. V5 said he expected staff to notify him on any new wounds within 24 hours or when he arrived in the facility to make rounds if it was found the day before he was to arrive to make rounds. V5 said he did not think it was appropriate for a facility to notify him of wounds 19 days after the wound was discovered. R1's 12/25/25 Initial Wound Evaluation & Management Summary documented in part . End-Stage Skin Failure Sacrum Full Thickness . End-Stage Skin Failure of the Left Buttock Full Thickness . Skin Tear Wound of the Right Buttock Full Thickness . R1's 12/1/24 through 12/31/24 Treatment Administration History documented a 12/25/24 order for Dakin's Solution 0.5% daily with special instructions cleanse wound to right buttock with wound cleanser or normal saline and apply Dakin's soaked gauze and cover with dry dressing. R1's 12/1/24 through 12/31/24 Treatment Administration History documented a 12/25/24 order for Dakin's Solution 0.5% daily with special instructions cleanse wound to left buttock with wound cleanser or normal saline and apply Dakin's soaked gauze and cover with dry dressing. No wound treatments orders prior to 12/25/25 were noted. R1's 1/2/25 hospital Wound Assessment Note documented in part . Scrotum MMPI (Mucous Membrane Pressure Injury), sacrum e/t b/l (and bilateral) buttocks evolving DTPI (Deep Tissue Pressure Injury) with epithelial separation noted . 2. R2's Resident Face Sheet documented an admitted [DATE] with diagnoses including: decreased ADL (Activities of Daily Living) function, diffuse large B-cell lymphoma. R2's 1/27/25 Brief Interview for Mental Status (BIMS) documented a score of 14, indicating R2 was cognitively intact. R2's 1/22/25 hospital After Visit Summary documented a 1/21/25 Emergency Department (ED) Provider Note documenting in part . Physical Exam . Genitourinay: . Patient has stage II (2) pressure ulcer on his sacrum which extends either side to about mid buttock. There is no obvious cellulitis or purulent drainage noted R2's 1/22/25 Initial Wound Evaluation & Management Summary documented in part . Stage 4 Pressure Wound of the Left Ischium . Primary Dressing . Alginate calcium apply once daily . Collagen powder apply once daily . Silver sulfadiazine apply once daily . Stage 4 Pressure Wound Sacrum Full Thickness Primary Dressing . Alginate calcium apply once daily . Collagen powder apply once daily . Silver sulfadiazine apply once daily . On 1/29/25 at 2:10 PM, R2 said the facility was not completing any treatments or putting any dressings on R2's pressure wounds on his bottom. R2 stated he had an antiseptic lotion he had brought from home with him to the facility and was putting on his wounds when staff assisted him to the bathroom. On 1/29/25 at 2:27 PM, staff assisted R2 to the bathroom and when R2's incontinent brief was removed no dressings were present to R2's left ischial or sacral wounds. R2's incontinent brief had several small blood clots from R2's wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 12:16 PM, V3 said she was the nurse who rounded with V5 every week and would put V5 treatment orders in the EMR when V5 sent his notes to the facility. V3 was asked if V5 gave verbal orders to V3 when V5 was rounding and V3 answered yes. V3 was asked why she did not put the orders in the EMR after rounding with V5 and V3 answered it was possible V5 would give a verbal order that was different than the order written on V5's notes when V5 sent them to the facility. V3 was asked what V3 would do if V5 did not send his notes for 2 to 3 days after rounding and would those residents not receive wound treatments, V3 answered she would call V5 to ask him to send his notes but was not sure if the residents would receive wound treatments due to no orders being in the resident's EMR. V3 said she was not sure why R2's 1/22/25 wound treatment orders had not been placed in R2's EMR. V3 said R2 did not have any wound treatments completed from R2 admission on 1/21/25 through 1/28/25. On 1/29/25 at 3:10 PM, V5 said he expected staff follow his orders for wound treatments. R2's Physician Order Report from 12/29/24 through 1/29/25 documented a 1/28/25 order for silver sulfadiazine cream 1% once a day with special instructions to cleanse wound to left ischium with normal saline or wound cleanser and apply silver sulfadiazine, collagen powder, calcium alginate and dry dressing and a 1/28/25 25 order for silver sulfadiazine cream 1% once a day with special instructions to cleanse wound to sacrum with normal saline or wound cleanser and apply silver sulfadiazine, collagen powder, calcium alginate and dry dressing. No other wound treatment orders were noted. R2's Wound Management Detail Report documented in part Wound Type . Pressure Ulcer . Wound Location . Left buttock Left ishium . Date/ Time Identified . 1/22/25 12:47 PM Created Date/ Time . 1/28/25 12:48 PM . Wound Type . Unspecified ulcer . Wound Location . Sacrum . Date/ Time Identified 1/22/25 12:49 PM Created Date/ Time . 1/28/25 12:50 PM . R2's 1/29/25 Wound Evaluation & Management Summary documented in part . Stage 4 pressure wound of the left ischium full thickness . Wound progress: . Improved evidenced by decreased surface area . Primary Dressing(s) . Alginate calcium apply once daily . collagen powder apply once daily . silver sulfadiazine apply once daily . 3. R3's Resident Face Sheet documented an admitted [DATE] with diagnoses including: secondary neoplasm of liver, pressure- induced deep tissue damage of sacral region. R3's 1/5/25 MDS documented a BIMS score of 13, indicating R3 was cognitively intact. R3's 1/1/25 Skin Observation documented in part . Skin Assessment . Pressure Injury/ Blister/ Open Areas . Yes- Sire (sic) and Description- sacrum . R3's 1/1/25 Admission Observation documented in part . Alterations in Skin . Does the resident have any alteration(s) in skin? . MASD- Moisture- Associated Skin Damage . Describe each skin integrity condition checked in detail . sacrum redness . Does the resident have a Pressure Ulcer(s) . yes . On 1/30/25 at 12:36 PM, V4 said she had been notified on Saturday 1/25/25 by a Certified Nursing Assistant (CNA) R3 had a wound to sacral area. V4 said the wound was dark red with darker areas inside the wound margins but was not open. V4 said she did not document R3's wound anywhere. V4 stated I was going to do what I needed to do about it like have someone take a picture of it and put it on (electronic communication system) but I got busy and completely forgot about it until Sunday or Monday. V4 said she notified V3 of R3's wound on 1/27/25 and a picture was sent to V5 for treatment orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1:28 PM, V13 (R3's Family Member) said R3 had a dark wound to the sacral area for about a week. V13 presented an undated picture of R3's sacral area with a large dark red area and said this was taken about a week ago. V13 presented another undated picture of R3's sacral area with a large open wound and said it had been taken on 1/28/25. V13 said she did not know if R3's wound was being treated. R3's 1/27/25 progress note documented as a late entry on 1/28/25 at 2:41 PM by V3 documented in part This nurse spoke with (V5) regarding the wound to the resident's sacrum/ coccyx. (V5) has ordered a treatment of Dakins soaked gauze and dry dressing to be done BID (twice a day) . R3's Treatment Administration History from 1/1/25 through 1/29/25 documented an order for 1/27/25 order for Dakin's Solution 0.5% apply Dakin's soaked gauze to sacrum/ coccyx ulcer and cover with dry dressing twice daily. R3's 1/29/25 Initial Wound Evaluation & Management Summary documented in part . End- stage Skin Failure Sacrum Full Thickness . Wound Size (length x width x depth): 7.6 x 5.2 x not measurable . Primary Dressing . Foam Silicone border apply once daily for 30 days . The facility's revised 1/20/23 Wound Management Program policy documented in part .5. The facility will assess residents weekly for current skin conditions . C. If any new areas are identified, write a nurse's note describing the area found and the protocol followed to treat it . F. The nurse will measure the area; call physician to obtain appropriate treatment order, call the guardian/ family member inform him/ her, document the area on the T.A.R. (Treatment Administration Record) and initiate the treatment . The facility's revised February 2012 Change in Condition policy documented in part . Procedure: . 1. The staff person who first notices the change in condition immediately to the licensed nurse . 3. The results of the assessment, including the vital signs, signs, symptoms and any physical and/ or mental changes in condition are documented in the resident's medical record . 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: . B. Deterioration in health, mental, or psychosocial status. C. Need to alter treatment .