

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Helia Healthcare of Energy		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51735</p> <p>Based on interview and record review, the facility failed to protect a resident from employee to resident verbal abuse for 1 of 10 residents (R3) reviewed for abuse in a sample of 12.</p> <p>The findings include:</p> <p>R3's Face Sheet documents an admitted [DATE] with diagnoses including Muscular Dystrophy, Adjustment Disorder with mixed anxiety and depressed mood, Multiple Sclerosis and Major Depressive Disorder. R3's Minimum Data Set (MDS) dated [DATE] documents that R3 has a Brief Interview for Mental Status (BIMS) score of 15 indicating that R3 is cognitively intact.</p> <p>On 4/16/25 at 10:25 AM, R3 stated the facility started a trial for vitamin IV (intravenous) bags and the first month she agreed to do it but the second month she refused it because she was having diarrhea and wasn't feeling the best. R3 stated when she refused the vitamin bag V2 (Director of Nursing) yelled at her and said she just cost the facility \$1,000 dollars. R3 stated she reported it to V1 (Administrator) and he had a meeting to tell everyone what the trial for the vitamin bag was and how long it went on. R3 said the next day or so V2 apologized to her for yelling at her in the lunchroom in front of everyone. R3 said that R8 and V7 (Certified Nursing Assistant/CNA) witnessed V2 yelling at her in the dining room.</p> <p>On 4/17/25 at 8:26 AM, R3 stated she feels safe at the facility, but she does feel like she needs to tip toe around V2. R3 stated she doesn't think she will do it again because she thinks V2 knew what she did was wrong. R3 stated she was a little embarrassed but was more angry at the situation.</p> <p>On 4/16/25 at 2:20 PM, R8 stated she was at the table in the dining room when V2 came to the table and yelled at R3 for not taking the IV fluids. R8 couldn't remember what exactly she said, just that she yelled at her and it was about 1 month ago. R8 was alert to person, place, and time.</p> <p>On 4/16/25 at 10:33 AM, R5 stated he witnessed V2 yell at R3 for refusing the IV therapy. R5 was alert and oriented to person, place, and time.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/17/25 at 9:36 AM, V7 (CNA) stated she was in the dining room when V2 raised her voice and heard it. V7 stated R3 told V2 that she didn't want to do the IV drip because she didn't feel good. V7 stated V2 raised her voice to R3 and told her it was already paid for and she would have to charge it anyways because they already paid for it. V7 stated V2 did raise her voice at R3 and seemed angry with R3. V7 stated she was sitting across the dining room when it happened and she could hear V2, she also stated it was loud enough that people could probably hear it down the hallway. V7 stated she felt that V2 was loud and aggressive when talking to R3. V7 said that after R3 went back to her room, V7 stated she went to check on her to make sure she was okay. V7 stated she didn't think V2 should talk to any resident that way.</p> <p>On 4/16/25 at 12:02 PM, V4 (CNA) stated she hasn't heard staff yell at residents but V2 does have a bad attitude.</p> <p>On 4/17/25 at 10:14 AM, V2 stated R3 agreed to take the IV therapy at a previous date and when the IV nurse came to do the clinic in March, R3 refused the IV. V2 stated if she doesn't tell the IV therapy nurse prior to them coming to the clinic to give it, they get charged for the bag of fluids even if the resident refuses. V2 stated she had a conversation in the dining room with R3 about her refusing and told her it was only vitamins and minerals. V2 stated she told R3 if she would have told her sooner that she didn't want it, she could have taken care of it. V2 stated she shouldn't have had that conversation with R2 in the dining room. V2 stated the next day she went to R3 in the dining room and apologized. V2 said when she makes a mistake, she apologizes for it. V2 stated she can't take it back but it won't happen again. V2 stated she apologized because she felt like she should, no one told her to do it. V2 stated she apologized in the dining room in front of the residents that the original incident happened in front of because she didn't want to do it privately. V2 stated that her voice is loud sometimes. V2 stated the way she delivered the conversation maybe wasn't the best and she felt like it was a miscommunication.</p> <p>On 4/17/25 at 10:30 AM, V1 (Administrator) stated he was made aware by someone that there was a misunderstanding about the IV therapy program, but he couldn't remember who made him aware. V1 stated he scheduled an impromptu resident council meeting and explained the IV infusion program to the residents. V1 stated he was not aware of any conversation between V2 and R3. V1 stated if someone tells him about any alleged abuse there has to be an immediate intervention. V1 stated the alleged abuser is suspended immediately pending investigation and he does the investigation right away.</p> <p>The facility policy titled Abuse Prevention Program (revision date 9/29/22) under Definitions documents Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology .Mistreatment: Mistreatment means inappropriate treatment or exploitation of a resident.</p>		