

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 05/07/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49663</p> <p>Based on interview and record review, the facility failed to notify the Power of Attorney (POA) of a fall and change in resident's condition for 1 (R1) of 3 residents reviewed for accidents.</p> <p>This past noncompliance occurred between 4/5/25 and 4/5/25.</p> <p>Findings Include:</p> <p>R1's Admission Record documents an admitted to the facility of 3/16/25 with diagnoses including displaced intertrochanteric fracture of right femur, altered mental status, unspecified, alzheimer's disease, unspecified and dementia in other diseases classified. This same document under emergency contacts listed V3 (Family) as emergency contact power of attorney for healthcare and primary financial contact.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 3, indicating R1 had severe cognitive impairment. The same MDS section GG documents that R1 has impairment in both sides of upper extremities (shoulder, elbow, wrist, hand) and impairment on one side for lower extremity (hip, knee, ankle foot) and uses a wheelchair as a mobility device.</p> <p>A facility incident report dated 4/4/25 documented V4 (Licensed Practical Nurse/LPN) notified V1 (Administrator), V2 (Director of Nursing/DON) and R1's Primary Care Physician of a fall R1 sustained.</p> <p>On 5/6/25 at 12:23 PM, V3 (Family) stated, he is R1's POA. V3 stated, he had not been notified by the facility about R1's fall and transfer to the local hospital on 4/4/25. V3 stated, he did not have any missed calls or messages from the facility. V3 stated he received his first call about R1's fall from the local emergency room at 3:06 PM on 4/4/25. V3 stated, he then called the facility to speak with V1 (Administrator) who stated he did not know anything about R1 falling and would look into the situation. V3 stated he had to initiate all calls with the facility on 4/4/2024 with regard to R1's care, the facility did not call him.</p> <p>On 5/2/25 at 12:55 PM, V4 (LPN) stated, she did attempt to contact V3 (Family) twice, unsuccessfully. V4 stated, there had not been a voicemail to leave a message and did not attempt to reach other emergency family listed.</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
---	-------	-----------

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 05/07/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/2/25 at 10:58 AM, V5 (Registered Nurse/RN) stated, he does contact family immediately for a change in condition. V5 stated the facility policy is to notify physician and power of attorney (POA) for any resident for a change in condition.</p> <p>On 5/6/25 at 9:02 AM V13, (Assistant DON/ADON) stated, all nursing staff should contact the physician and POA for a resident with a change in condition, which would include a fall and being transferred to local the hospital.</p> <p>On 5/4/25 at 11:42 AM, V14 (LPN) stated, she would contact the physician and POA for any resident who had a change in condition.</p> <p>On 5/6/25 at 12:40 PM, V1 (Administrator) stated, V4 should have contacted V3 (Family) prior to calling for an ambulance. V1 stated, R1 was unable to make her own decisions. V1 stated, he does not recall the conversation with V3 (Family).</p> <p>Facility Change in Condition policy (revised February 2012) documented under Definition, change in condition is defined as an improvement or decline in the resident's physical, mental or psychosocial status that effects less than two areas of activities of daily living This same document under Procedure, 5. The resident's designated medical contact or guardian will also be notified. In certain circumstances, the change may warrant contacting clergy or other significant persons. Nursing judgment should be used given the time of day and the severity of the resident change.</p> <p>Throughout the survey, the facility was unable to provide reproducible evidence that V3 was contacted by the facility prior to the hospital notifying V3 with regard to R1's fall and change in condition.</p> <p>Prior to this survey date, the facility took the following actions to correct the non-compliance:</p> <p>1. Immediate Corrective Action for those affected by the deficient practice:</p> <p>Clinical Staff education on fall policy regarding physician and family notification completed on 4/5/25 by V2 (DON).</p> <p>Clinical staff educated on change of condition on 4/5/25 by V2 (DON).</p> <p>Individual staff educated to ensure notifications are made with falls and change in condition on by V2 (DON).</p> <p>2. Process/Steps to identify others having the potential to be impacted by the same deficient practice:</p> <p>All residents are at risk to be affected by this deficient practice completed by V2 (DON) from 3/5/25 - 4/5/25.</p> <p>3. Measures put into place/systematic changes to ensure the deficient practice does not recur:</p> <p>Falling audited for last 30 days to ensure documentation of notification made completed by V2 (DON) on 4/5/25.</p> <p>(continued on next page)</p>		

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 05/07/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. DON/designee will monitor the facility activity for falls and change in condition 2 times a week for compliance for 4 weeks.</p> <p>DON/designee will complete a fall audit to ensure interventions, notifications made on two residents, two times weekly for four weeks to ensure compliance started on 4/5/25. V2 completed the audits completed by 5/1/25.</p> <p>Any concerns will be communicated to the Quality Assurance (QA) Committee.</p> <p>5. QAPI (Quality Assurance and Performance Improvement) meeting held on 4/5/45 with V1 (Administrator), V2 (DON), V3 (Assistant DON) and V15 (Regional Director) in attendance to review falls and notification requirements.</p>

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 05/07/2025
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 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49663</p> <p>Based on interview and record review, the facility failed to ensure necessary supervision was provided to prevent a fall with injury for 1 (R1) of 3 residents reviewed for accidents and supervision. This failure resulted in R1 being found in the floor resulting in mildly displaced left lateral sixth and seventh rib fractures and an acute, mildly displaced, and angulated fracture of the left femoral neck.</p> <p>Findings include:</p> <p>R1's Admission Record documents an admitted to the facility of 3/16/25 with diagnoses including displaced intertrochanteric fracture of right femur, altered mental status, unspecified, alzheimer's disease, unspecified and dementia in other diseases classified.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 had severe cognitive impairment. The same MDS section GG documents that R1 has impairment in both sides of upper extremities (shoulder, elbow, wrist, hand) and impairment on one side for lower extremity (hip, knee, ankle foot) and uses a wheelchair as a mobility device.</p> <p>R1's Care Plan documented a focus area of R1 at risk for falling related to alzheimers disease/dementia, with interventions including observe frequently and place in supervised area when out of bed.</p> <p>On 5/2/25 at 9:40 AM, V3 (Family) stated R1 had been transferred to this facility for rehabilitation after a fracture to her right femur. V3 stated R1 had 4 falls within one month time frame that she had been in the facility. V3 stated R1 had been significantly injured in two of the falls that included a laceration to the lip and fracture to the left hip. V3 stated he did not receive any communication from the facility on R1's fall on 4/4/2025 when she had been transported to the local hospital.</p> <p>On 5/2/25 at 10:49 AM, V11 (Certified Nurse Assistant/CNA) stated she was familiar with R1 and has cared for her. V11 stated R1 did have multiple falls while in the facility. V11 stated R1 did have a habit of trying to get up from her wheelchair without assistance.</p> <p>On 5/2/25 at 10:58 AM, V5 (Registered Nurse/RN) stated he was familiar with R1 and has cared for her. V5 stated R1 had a habit of trying to stand up from her wheelchair and had been at risk for falls. V5 stated R1 should not be out of staff's line of sight because of her impulsive behavior of trying to stand without assistance anytime she was in her wheelchair. V5 stated nurses are to report to another nurse when they are leaving the unit floor and CNA staff are to report to the nurse when they are leaving the unit floor so there is coverage. V5 stated, he had never had 2 staff members off the unit floor together, it should always be a rotation.</p> <p>(continued on next page)</p>		

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 05/07/2025
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/2/25 at 10:59 AM, V9 (Nurse Practitioner/NP) stated, she did have direct patient care with R1. V9 stated R1 was confused and always trying to stand up from her wheelchair without assistance. V9 stated, that R1 needed constant care and if you took your eyes off of her, she would attempt to get up out of her wheelchair. V9 stated she had observed multiple times staff redirecting R1 when she would try to stand without assistance.</p> <p>On 5/2/25 at 11:20 AM, V8 (Physical Therapy Assistant/PTA) stated, she did have direct care with R1. V8 stated she provided services to R1 that included ambulation, balance, walking and strengthening. V8 stated R1 was very confused most of the time and did attempt to stand on her own frequently from her wheelchair. V8 stated R1 did have multiple falls while in the facility. V8 stated R1 needed a lot of verbal cues during therapy, but would respond to them. V8 stated R1 was a fall risk and should not have been out of staff sight. V8 stated, on 4/4/2025, V6 (CNA) came to the physical therapy room to ask her to stay with R1 who had fallen in the dining room.</p> <p>On 5/2/25 at 12:07 PM, V7 (CNA) stated he didn't normally work with R1 and had been pulled from his usual unit to work R1's unit/hall on 4/4/2025 when R1 had been found in the dining room floor. V7 stated V4 (Licensed Practical Nurse/LPN) had left R1's unit/hall (where she was assigned) to go to a different hall in the facility for a few minutes sometime after 1:00 PM. V7 stated R1 had been sitting at the dining room table with another resident when he also left the unit to go to his car outside the building to get his vital sign equipment and was gone for about 5 minutes. V7 stated he did not notify anyone that he had left the hall to go outside. V7 stated it is the facility process for CNA's to notify the nurse when leaving the floor to help make sure the floor has coverage. V7 stated there was no staff member in the dining room with R1 when he left. V7 stated when he was walking back down the hallway with V4 (LPN) around 1:14 PM when V6 (CNA) notified them that R1 had been found in the dining room floor.</p> <p>On 5/2/25 at 12:13 PM, V6 (CNA) stated, on 4/4/25 she had been working on R1's unit. V6 stated she had been pulled to work R1's hall that day, however, does not normally work there. V6 stated she had been in another resident's room when she heard yelling help, help, help around 1:14 PM. V6 stated when she went out to the dining room, R1 was lying on the floor and no other staff was present. V6 stated she asked V8 (Physical Therapy Assistant/PTA) to stay with R1 while she notified V4 (LPN). V6 stated she had not been aware that V4 and V7 were off the floor. V6 stated it is the facility process for nurses to notify another nurse and CNA's to notify the nurse when leaving the floor to help with coverage on the unit.</p> <p>On 5/2/25 at 12:55 PM, V4 (LPN) stated she had been working R1's unit hall on 4/4/2025. V4 stated R1 was at risk for falls and did attempt to stand without assistance, frequently. V4 stated she did leave the unit floor sometime after 1:00PM to get keys from another unit floor nurse. V4 stated she had not been aware that V7 (CNA) had left the unit floor after she had. V4 stated on her way back to the unit floor around 1:14 PM, she bumped into V7 heading back to the unit floor at the same time. V4 stated V6 (CNA) notified her that R1 had been found lying on the dining room floor.</p> <p>On 5/2/25 at 2:25 PM, V2 (Director of Nursing/DON) stated R1 had been admitted to the facility as a fall risk. V2 stated there should be 1 nurse and 2 CNA's working each unit. V2 stated, if a nurse is leaving their unit floor they should notify another nurse in the building for coverage. V2 stated, if a CNA is leaving their unit floor then they should notify their nurse for coverage. V2 stated her expectation for staff is to follow facility process of notifying another team member for coverage when they leave the unit floor. V2 stated there should not be 2 teammates off the floor together.</p> <p>(continued on next page)</p>		

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 05/07/2025
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/6/25 at 9:02 AM, V13 (Assistant DON/ADON) stated the facility will have 2 CNA's and one nurse to each unit and then a float CNA for the building. V13 stated it is the process of all staff members to notify another teammate when leaving the unit floor for coverage. V13 stated there should not be 2 teammates off the floor at the same time.</p> <p>R1's Fall Risk assessments dated 3/16/25, 3/17/25, 3/25/25, 3/27/25 and 4/5/25 all documented R1 was a high fall risk.</p> <p>R1's Progress Note dated 3/25/25 at 2:17 PM documented At 1310 (1:10 PM), this resident fell in the dining room. She was trying to get up and walk, lost her balance and fell . I and the CNA were not able to catch her. She hit her right arm with no injuries and good ROM (range of motion). Landed on her back. No injuries noted. Paperwork being done and notifications made.</p> <p>R1's Progress Note dated 3/27/25 at 5:50 AM documented Resident was sitting in a wheelchair at the sink in her bathroom brushing her teeth when she attempted to stand without assist. Resident was found in the floor, laying on her left side. No shortening or rotation to BLE (bilateral extremities). Hematoma noted above the left eye. No other injuries observed. Resident placed back in wheelchair with assist x (times) 2. Spoke to (name of V9/NP). No new orders received at this time. She will be in this morning to assess Resident. Detailed message left with (name of V3/POA). Message sent through (name of messaging app) to notify Administration. Neuro's started. Fall report complete. Resident currently sitting in dining room watching television.</p> <p>R1's Progress Note dated 3/31/25 at 11:00 AM documented the resident was sitting in her wheelchair in her room prior to lunch. (Name) with activities witnessed the fall, she stated the resident stood up and fell face first hitting her head off the floor. Assessed resident no rom (range of motion) or shortening of extremities noted. She has a laceration to her top lip. Vitals are 146/78, P98, temp 98.3, R 20, o2 975 room air. She is stating that she is dizzy . The progress note also documented a fall mat was placed in the resident room and bed in lowest position.</p> <p>R1's Progress Note dated 04/04/25 at 1:31 PM documented it was recorded as a Late Entry on 4/4/25 at 4:01 PM by V4 (LPN). The progress note documented Called to dining room at approx. 1:14 PM by CNA. Resident found to be laying in floor. Resident c/o (complained of) left hip pain. (Name of ambulance company) called to transport resident to (name of local hospital) for further evaluation.</p> <p>R1's Progress Note dated 04/04/25 at 4:01 PM documented Called (name of local hospital) to follow up on resident. Nurse states patient will be admitted for fx (fracture) left hip. Nurse will call back with further details.</p> <p>The facility incident report dated 04/04/25 documented V4 (LPN) had found R1 lying on the floor in the dining room. R1 had been identified of having poor safety awareness. The resident had been sitting at the table prior to fall with brakes to wheelchair locked. V4 stated wheelchair had been found with brakes unlocked and sitting behind resident.</p> <p>(continued on next page)</p>		

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 05/07/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Local hospital History of Present Illness (HPI) dated 04/04/25 at 2:16 PM documented under Chief Complaint: Patient presents with fall. This is reported to be (R1's) 3rd fall in 1 month. R1 had an unwitnessed fall. Two weeks ago, she fell and broke her proximal femur in right side. Then she fell and hit her face with sutures in the lips and third is left leg. This same document on page 8 documented a computed tomography scan dated 04/04/25 with results of mildly displaced left lateral sixth and seventh rib fractures and on page 9 under electromagnetic waves (X-ray) of the hip left included pelvis results of acute, mildly displaced, and angulated fracture of the left femoral neck.</p> <p>The facility Falls Management (revised 4/21/2022) documented under Policy it is the policy of (facility name) to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions.</p> <p>The facility staffing policy (revised 1/2023) documented under Policy, The facility provides adequate staffing to meet needed care and services for our resident population and according to regulatory staffing requirements (CMS, IDPH). Under Procedure, 1. Our facility maintains adequate staffing on each shift to ensure that that our resident's needs and services are met and schedules adequate staff to meet or exceed individual state requirement. 2. Licensed registered nurse and licensed nursing staff are available to provide and monitor the delivery of resident care services 3. Certified Nursing Assistants are available each shift to provide and monitor the delivery of resident care services of each resident as outlined on the resident's comprehensive care plan.</p>		