

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 07/24/2025
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review the facility failed to ensure prevention of misappropriation of resident property for 3 (R2, R3, and R5) of 6 residents reviewed for abuse in the sample of 13. The Findings Include: 1. R2's Face Sheet dated 07/17/25 documents an admission date of 12/19/24 with diagnoses in part of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, pain in left knee, malignant neoplasm of oropharynx, squamous cell carcinoma of skin of scalp and neck, malignant neoplasm of esophagus. R2's Minimum Data Set (MDS) dated [DATE] documents in Section C a BIMS (Brief Interview for Mental Status) score of 13, which indicates that R2 is cognitively intact. R2's Physician Order Report dated 06/17/25 to 07/17/25 documents a prescription with a start date of 12/27/24 with an end date of open ended of oxycodone 5mg (Milligrams) 1 tablet every 4 hours for pain. R2's Medication Administration History dated 07/01/25 to 07/17/25 documents oxycodone 5mg administer 1 tablet every 4 hours PRN (as needed) for pain which documents on 07/08/25 an administration at 6:05PM by V6 (Registered Nurse/RN), 6:06PM by V6 (RN) and 6:22PM by V7 (RN). R2's Medication Administration History also documents oxycodone was administered 2 times by V6 on 07/12/25 both given at 6:23PM. R2's Controlled Substance Report dated 07/01/25 to 07/20/25 documents on 07/08/25 at 6:05PM oxycodone every 4 hours PRN 1 tablet was administered by V6, on 07/08/25 at 6:05PM oxycodone every 4 hours PRN 1 tablet was administered by V6, on 07/08/25 at 6:22PM oxycodone every 4 hours 1 tablet was administered by V7 (RN). R2's Controlled Substance Report also documents on 07/12/25 V6 administered oxycodone 2 times, both at 6:23PM. On 07/16/25 at 3:10PM, R2 stated that he doesn't know of any problem with his medications. R2 said that when V7 (RN) works that he doesn't know what medication he is getting because she will crush all his medication up, so he doesn't know what all is in the cup. R2 said that V7 (RN) tells him that there is a pain pill in the crushed-up medications, but he doesn't know for sure. R2 said that sometimes the pain medication works, other times it doesn't. 2. R3's Face Sheet dated 07/17/25 documents an admission date of 06/04/25 with diagnoses in part of unspecified fracture of left acetabulum, subsequent encounter for fracture with routine healing, Phantom limb syndrome pain, pain unspecified, pain in left shoulder, and chronic lymphocytic leukemia. R3's MDS dated [DATE] documents in Section C a BIMS score of 11 which indicates moderately impaired cognition. R3's Physician Order Report for 06/17/25 to 07/17/25 documents a prescription with a start date of 06/04/25 and an end date of open ended for oxycodone 15mg give 1/2 tablet (7.5) every 4 hours PRN (as needed) dx (diagnosis) displaced fracture of anterior wall of left acetabulum. R3's Medication Administration History for 07/01/25 to 07/17/25 documents on 7/1/25 oxycodone 15mg administer 1/2 tablet was administered at 6:24PM and at 6:25PM both by V6 (RN), on 07/07/25 administered at 6:19PM by and at 6:20PM both by V7 (RN), on 07/08/25 administered at 6:04PM and at 6:05PM both by V6 (RN), on 07/12/25 administered 2 times at 6:21PM both by V6 (RN), and at 6:51PM by V7 (RN), on 07/13/25 administered at 6:24PM and at 6:26PM both by V6 (RN). R3's Controlled Substance Report from 07/01/25 to 07/20/25 documents on 07/01/25 at 6:24PM and 6:25 PM oxycodone every 4 hours 1 tablet administered by V6 (RN), on 07/04/25 at 6:11PM oxycodone every 4 hours corrected by V7 (RN) for 2 tablets comment documents correction at shift change with V6 (RN), at 6:36PM 1 tablet administered by V6 (RN), on 07/07/25 oxycodone 1 tablet administered at 6:19PM by V6 (RN) and at 6:20PM by V7 (RN), on 07/08/25 oxycodone every 4 hours 1 tablet administered at 6:04PM and 6:05PM by V6 (RN), at 5:02AM V7 administered 1 tablet and at 5:16AM V7(RN) has 1 tablet documented as correction resident dropped. On 07/12/25 at 6:21PM oxycodone every 4 hours 2 tablets administered by V6 (RN) and at 6:21PM by V6 (RN) another 1 tablet administer and then V7 (RN) administered another 1 tablet at 6:51PM, at 10:38 PM V7 (RN) signed out 2 tablets and comment documents tab wasted resident dropped. On 07/13/25 at 6:24PM oxycodone every 4 hours 1 tablet administered by V6 (RN) and then again at 6:26PM another 1 tablet administered by V6 (RN). On 07/21/25 at 3:06PM, R3 said that he gets his medication as ordered as far as he knows. R3 didn't have a problem with his medication administration. R3 said that he has never dropped any of his pain pills and that he always takes his medication with no problem. 3. R5's Face Sheet dated 07/17/25 documents an admission date of 05/28/25 with diagnoses in part of pressure ulcer of buttock, pain nondisplaced fracture of anterior wall of right acetabulum, and pain in unspecified joint. R5's MDS dated [DATE] documents in Section C a BIMS score of 04 which indicates R5 is cognitively impaired. R5's Physician Order Report dated 06/17/25 to 07/17/25 documents a prescription with a start date of 05/28/25</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to report allegations of abuse and misappropriation of property within the required time frames for 3 (R2, R3, and R5) of 6 residents reviewed for abuse in a sample of 13The Findings Include: 1.R2's Face Sheet dated 07/17/25 documents an admission date of 12/19/24 with diagnoses in part of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, pain in left knee, malignant neoplasm of oropharynx, squamous cell carcinoma of skin of scalp and neck, malignant neoplasm of esophagus.R2's Minimum Data Set (MDS) dated [DATE] documents in Section C a BIMS (Brief Interview for Mental Status) score of 13, which indicates that R2 is cognitively intact.R2's Physician Order Report dated 06/17/25 to 07/17/25 documents a prescription with a start date of 12/27/24 with an end date of open ended of oxycodone 5mg (Milligrams) 1 tablet every 4 hours for pain.R2's Medication Administration History dated 07/01/25 to 07/17/25 documents oxycodone 5mg administer 1 tablet every 4 hours PRN (as needed) for pain which documents on 07/08/25 an administration at 6:05PM by V6 (Registered Nurse/RN), 6:06PM by V6 (RN) and 6:22PM by V7 (RN). R2's Medication Administration History also documents oxycodone was administered 2 times by V6 on 07/12/25 both given at 6:23PM.R2's Controlled Substance Report dated 07/01/25 to 07/20/25 documents on 07/08/25 at 6:05PM oxycodone every 4 hours PRN 1 tablet was administered by V6, on 07/08/25 at 6:05PM oxycodone every 4 hours PRN 1 tablet was administered by V6, on 07/08/25 at 6:22PM oxycodone every 4 hours 1 tablet was administered by V7 (RN). R2's Controlled Substance Report also documents on 07/12/25 V6 administered oxycodone 2 times, both at 6:23PM. 2. 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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to initiate and complete investigations of abuse allegations in accordance with required time frames for 3 (R2, R3, and R5) of 6 residents reviewed for abuse in a sample of 13. The Findings Include: 1. R2's Face Sheet dated 07/17/25 documents an admission date of 12/19/24 with diagnoses in part of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, pain in left knee, malignant neoplasm of oropharynx, squamous cell carcinoma of skin of scalp and neck, malignant neoplasm of esophagus. R2's Minimum Data Set (MDS) dated [DATE] documents in Section C a BIMS (Brief Interview for Mental Status) score of 13, which indicates that R2 is cognitively intact. 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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to properly dispose of controlled substance medication for 2 (R2 and R3) of 6 residents reviewed for pharmacy services in a sample of 13. The Findings Include:1. R2's Face Sheet dated 07/17/25 documents an admission date of 12/19/24 with diagnoses in part of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, pain in left knee, malignant neoplasm of oropharynx, squamous cell carcinoma of skin of scalp and neck, malignant neoplasm of esophagus.R2's Minimum Data Set (MDS) dated [DATE] documents in Section C a BIMS (Brief Interview for Mental Status) score of 13, which indicates that R2 is cognitively intact.R2's Physician Order Report dated 06/17/25 to 07/17/25 documents a prescription with a start date of 12/27/24 with an end date of open ended of oxycodone 5mg (Milligrams) 1 tablet every 4 hours for pain. R2's Controlled Substance Report dated 07/01/25 to 07/20/25 for oxycodone every 4 hours PRN (as needed) documents on 07/01/25 at 7:12PM, 07/03/25 at 4:02AM, and 07/10/25 at 12:38AM by V7 (Registered Nurse/RN) an amount of 1 tablet documents an action of correction with a reason of other and documents correction under comments. 2. R3's Face Sheet dated 07/17/25 documents an admission date of 06/04/25 with diagnoses in part of unspecified fracture of left acetabulum, subsequent encounter for fracture with routine healing, Phantom limb syndrome pain, pain unspecified, pain in left shoulder, and chronic R3's Face Sheet dated 07/17/25 documents an admission date of 06/04/25 with diagnoses in part of unspecified fracture of left acetabulum, subsequent encounter for fracture with routine healing, Phantom limb syndrome pain, pain unspecified, pain in left shoulder, and chronic lymphocytic leukemia.R3's MDS dated [DATE] documents in Section C a BIMS score of 11 which indicates moderately impaired cognition.R3's Physician Order Report for 06/17/25 to 07/17/25 documents a prescription with a start date of 06/04/25 and an end date of open ended for oxycodone 15mg give 1/2 tablet (7.5) every 4 hours PRN (as needed) dx (diagnosis) displaced fracture of anterior wall of left acetabulum. 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V1 stated that they did do a disciplinary action with V7 (RN) regarding making sure that when disposing of controlled substances that she has another nurse to witness the dispose of the controlled substance.On 07/16/25 at 1:15PM, V2 (Director of Nursing/DON) stated that on R3 that V7 (RN) stated that she signed out so many and had correction and others marked was because R3 would drop the medication a lot and V7 (RN) would have to get a new pill. V2 said that she did give V7 (RN) a disciplinary action with V7 (RN) regarding making sure when she is disposing of controlled substance, she has another nurse present to witness the disposal. V2 said that V7 told her that she did have a witness when she disposed of controlled substance, she just forgot to have them sign that they witnessed.On 07/16/25 at 5:34PM, V7 (RN) stated that she was given a disciplinary action from V2 (DON) regarding not disposing of controlled substance properly by not having a witness to observe the disposal of the controlled substance. V7 said that when she marks other or correction on the controlled substance reports that she usually always put something under the comment section. V7 said if there is nothing under the comment section of the controlled substance report for she doesn't know why. V7 said that she does have another witness when she must dispose of a controlled substance, she just forgets to have them sign the controlled substance report form. V7 said that will never happen again. V7 said that R3 will drop his controlled substance often and she will have to get another one out or the pill has disintegrated because it is only a half of tab and it falls apart easy when you pop it out.On 07/22/25 at 12:03PM, V6 (Registered Nurse) stated that he did not do a correction with V7 (RN) on 07/04/25 and that he doesn't know why his name is in the comments on R3's-controlled substance report. V6 stated that he has never witnessed or disposed of any controlled substance with V7 (RN).A documents titled Employee Disciplinary Action with a date of 07/13/25 documents employee name of V7 (RN) A description of infraction</p>		