

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 09/04/2025
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 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</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 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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 provide behavioral health services for residents with mental illness, and to maintain/improve resident's psychosocial well-being for 1 of 3 residents (R1) reviewed for behavioral services in a sample of 9. This failure resulted in R1 voicing feelings of isolation, suicidal ideations with a plan of strangulation, and engaging in self-injurious behaviors. This failure resulted in an Immediate Jeopardy, which was identified to have begun on 4/14/25 when the facility failed to implement increased monitoring for R1, remove hazardous objects from R1's room, and refer R1 for recommended counseling services. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 8/22/2025 at 9:03 AM. The surveyor confirmed through observation, interview, and record review that the Immediate Jeopardy was removed on 8/22/2025, but the noncompliance remains at Level Two due to additional time to evaluate implementation and effectiveness of training. The findings include: R1's Face Sheet documents an admission date of 4/3/2025 and includes diagnoses of Bipolar Disorder, Depression, Generalized Anxiety Disorder, Personality Disorder, Suicidal Ideations, Poisoning by unspecified drugs medicaments and biological substances, intentional self-harm, subsequent encounter, and Genetic related Intellectual Disability. R1's MDS (Minimum Data Set) dated 7/10/025 includes a BIMS (Brief Interview for Mental Status) score of 15, indicating R1 is cognitively intact. Section GG- Functional Abilities documents R1 is independent for ADL's (Activities of Daily Living). Section D -Mood documents R1 has frequent symptoms of feeling down, depressed or hopeless. Section E-Behavior documents Behavior Symptoms documents 'Behavior not exhibited for Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)A document in R1's medical record titled Crisis Intervention Clinical Assessment dated 3/22/2025 (prior to R1's admission) from a Psychiatric Consultant group documents R1 had suicidal ideation for 2-3 days, and 2 months ago tried strangling herself with a bed sheet but stopped herself. The document showed R1 had a suicidal plan, and the plan was to wrap cord or string around her neck. R1's Care Plan documents a Problem area of Behavioral Symptoms; R1 has episodes of yelling and screaming, refusing and resisting care. Agitation and angry outburst dated 8/15/2025 with a goal of R1 will not hurt self or others during episodes of aggressive behaviors and will receive adequate care by next review dated 6/30/2025. Documented interventions include meds as ordered, notify MD (Medical Doctor) as needed, observe for changes in mood/cognition and behavior, psych consult (5/14/2025) as ordered and as needed, redirect R1 as needed, and remove R1 as needed to prevent harm to self or others. R1's Care Plan also documents a Problem area of Mood State: R1 with diagnosis of Bipolar/suicide ideations, start date of 4/22/2025 and edit date of 8/15/2025. The Goal documented is R1 will voice whenever she is feeling down and depressed or anxious (suicide ideations), edit date 6/30/2025. Documented interventions include: 1. Listen to R1 and validate feelings. 2. 1:1 given weekly with social services. 3. Let Psych Nurse Practitioner know of any issues. 4. Give Medications as ordered. 5. If R1 talks of suicide ideations will follow directions as given by Nurse Practitioner or Medical Doctor, created date of 4/25/2025. R1's Care Plan also documents a Problem area of R1 will punch self in face causing self-harm with a start date of 4/25/25 and edit date of 8/15/25. The Goal documented is R1 will not cause harm to self /others when becomes upset. Documented interventions for this Problem area include: 1) listen to resident and validate feelings 2) remind resident punching self doesn't solve anything 3) try to get resident to talk through her feelings 4) remind resident we are here to help 5) give medications as ordered 6) psych Nurse Practitioner made aware of situation ASAP for direction if needed with a start date of 4/25/25 and edit date of 5/1/25. R1's Progress Notes document the following: 4/14/2025: R1 sent to ER for stating she had bad thoughts, were very strong, wanting to strangle herself and began punching self in her face. Resident returned on 4/14/2025 with a recommendation to refer R1 to (Name of Counseling Service) for counseling. 4/15/2025: R1 continued to have suicidal ideations and asked to be sent to hospital stating she was going to hurt herself when staff leaves room. Resident placed on 1:1. R1 called 911 herself for transfer to local hospital. R1 was transferred to local hospital and the local hospital transferred R1 to another hospital. R1 returned to facility on 4/21/2025 with medication changes. 4/21/2025: R1 was sent back out to the local hospital for suicidal behaviors/ideations, screaming, crying out, punching self in the face and bouncing head off of the headboard. R1 returned to facility on 4/22/2024 at 4:13AM 4/24/2025: R1 sent to ER for suicidal</p>		