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	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Healthcare of Energy	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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure residents are free from significant medication errors for 1 of 3 residents (R1) reviewed for medication errors in sample of 13. This failure resulted in R1 receiving another resident's medication and being hospitalized for hypoglycemia.Findings Include:R1's Face Sheet shows documents an admission date of 10/16/2023 and includes diagnoses of Type 2 diabetes mellitus without complications, Alzheimer's Disease, Iron Deficiency, Cholecystitis, Renal Insufficiency, and Diaphragmatic Hernia without Obstruction. R1's Minimum Data Set (MDS) dated [DATE] documents in section C, Cognitive Patterns, documents a Brief Interview for Mental Status (BIMS) score of 5, indicating R1 has severe cognition impairment. R1's Progress Note dated 8/30/2025 at 8:46AM, documents Asked patient (R1) her name she said it was other residents name gave her that residents meds. BG (blood glucose) was 44 so gave orange juice with sugar to raise BG to 77. Notified ADN (V3 Assistant Director of Nursing), called ambulance, notified provider (name of provider).R1's Progress Note dated 8/30/25 at 10:35PM documents that the local hospital was contacted for an update and R1 was admitted for Hypoglycemia.On 9/5/2025 at 3:16PM, V9 (Licensed Practical Nurse/LPN) stated she was the nurse that accidentally gave R1 the wrong medications. V9 said prior to administering the wrong medications to R1, she saw R1 while R1 was in R1's room lying in bed. V9 stated when she checked R1's blood sugar, R1's blood sugar was 44. V9 said she provided R1 with some orange juice. V9 said after R1 drank the orange juice V9 rechecked R1's blood glucose and it had come up to 77. V9 said later in V9's shift (during morning medication pass) R1 was sitting in the dining room and when V9 asked R1 her name, R1 gave V9 the wrong name and gave the medications of the name (the name of R6) R1 gave her. V9 stated after she gave R1 the medications, a CNA stated, that is R1 not R6. V9 stated that is when she knew she made a medication error. V9 stated she could not remember what the medications were that she administered to R1 but they were R6's morning meds. V9 said when she realized the medication error had occurred, she reported this to V2 (Director of Nursing/DON) and then she sent the resident to the Emergency Room. V9 stated she does not work very often because she is in school, so she is not real familiar with some of the residents. V9 stated she also had called the physician and the Power of Attorney about the incident. V9 stated she had not administered R1's medications that were prescribed for that morning ordered for 7:00 AM to 10:00 AM after realizing her error. V9 stated she just received education from V2 on the date the medication error occurred (8/30/2025), on Medication Administration.R6's Medication Administration Record shows the AM (7:00AM-10:00AM) medications ordered for R6 that was given to R1 were Colace 100mg capsule, Ferrous Sulfate 325mg tablet, Furosemide 20mg tablet, Gabapentin 100mg capsule, Januvia 100mg tablet, Levothyroxine 125 mcg tablet, Lisinopril 20mg tablet, Magnesium Oxide 400mg tablet, Metformin 500mg tablet plus 250 mg tablet to equal 750 mg total, and Vitamin D3 50mcg capsule. R1's Physician Order Sheet documents an order for Lantus Solostar Insulin of 15 units subcutaneous once a day with an order date of 10/16/2023 and an order for BS checks dated 10/16/2023 for three times a day 7AM-10AM, 11AM-1PM, and 3PM- 6PM with sliding scale Regular Insulin per results.R1's Medication Administration Record dated 8/1/2025-8/31/2025 at 4:00AM-6:00AM documents R1 received Lantus Solostar Insulin 15 units subcutaneous and documents that it was administered by V19 (Registered Nurse). On 8/30/2025 at 7:00AM-10:00AM R1's blood sugar is documented as Low. On 9/5/2025 at 11:05AM, V2 stated she was made aware of the medication error and R1 was sent to the emergency room and was admitted for Hypoglycemia. V2 stated an investigation was initiated. V2 stated that V9 was educated on Medication Administration.R1's Event Summary Report dated 8/30/2025 at 8:42AM documents the medication error under event details and the type of error as incorrect medication. This report documents under Interventions that V2 (Assistant Director of Nursing) was notified and R1's blood glucose level dropped to 44 and R1 was given orange juice with sugar raising R1 blood glucose to 77 after 20 minutes. Report shows Physician was notified on 8/30/2025 at 9:00AM, Family was notified at 9:00AM, and Care Plan was reviewed at 9:00AM. Evaluation: Sent to emergency room for evaluation and treatment.On 9/5/2025 at 7:15AM, V17 (Emergency Medical Technician/EMT) stated he has gone to the facility twice to pick up R1. V17 said one time was to transport R1 to the hospital due to R1 receiving the wrong medications that were actually for another resident. V17 stated the medications that were accidently given to R1 was documented on the run report. R1's (Emergency Medical Service) Report from the local EMS agency dated 8/30/2025 documents a chief medical complaint of Accidental Medication