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	12/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to respect resident preferences and privacy for 2 of 4 residents (R17, R19) reviewed for resident rights in a sample of 44.Findings include:1. R19's Face Sheet documents an admission date of 9/26/25 with diagnoses including: cellulitis of right lower limb, weakness, depression, and other specified hearing loss bilateral.R19's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 07, indicating R19 has severe cognitive impairment.On 12/8/25 at 11:01 PM, V37 (License Practical Nurse) stated she works 6p-6a. V37 stated she starts doing wound treatments around midnight to 2:30 AM.On 12/08/25 at 11:41 PM, V37 was observed going to do a wound treatment on R19. V37 knocked on R19's door and R19 was asleep in her bed, she woke R19 up and told her she was going to do her treatment.On 12/09/25 at 12:11AM, R19 stated she was tired, and she doesn't like getting her dressing done at night, she would prefer to sleep, but she must get it done so she lets them do the dressing. R19 said that she would prefer just to sleep, and have it done when she is awake.On 12/18/25 at 9:10 AM, V2 (Director of Nursing/DON) stated wound care has been done at night since she started working at the facility 6.5 years ago. V2 stated it is hard to get it completed during the day because the resident isn't always in their room or bed, or they might be out of the building. V2 stated she isn't aware of anyone asking the residents if it is okay to wake them up in the middle of the night, she considers consent when the nurse goes into the room and says it's time for your wound treatment and the resident says okay. V2 stated if the treatment isn't completed by about midnight, then it should be put off until around 5am when they wake up.2. R17's Face Sheet documents an admission date of 10/16/2023 with diagnoses including: Alzheimer's disease, type 2 diabetes, protein-calorie malnutrition, pain, cellulitis of unspecified part of limb, and need for assistance with personal care.R17's MDS dated [DATE] documents a BIMS score of 04, indicating R17 has severe cognitive impairment.On 12/9/25 at 12:09 AM, observed wound care for R17. V25 (Registered Nurse) pulled R17's top up exposing her right side of abdomen that was facing the door without closing the door or pulling the curtain to provide privacy.On 12/18/25 at 9:10 AM, V2 stated the door should be shut to provide privacy when performing a wound treatment.A facility policy title Resident Rights dated August 31, 2023, documents under Resident Rights A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. In the same policy it documents under Self-Determination The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in this section. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to supply linens (washcloths) and ensure the call lights were within reach for 6 of 6 residents (R1, R3, R4, R7, R22, R35) reviewed for accommodation of needs in a sample of 44. Findings include:1. On 11/26/25 at 2:34 PM, V7 (Certified Nursing Assistant/CNA) stated he ran out of washcloths about 2 weeks ago and had to use a pillowcase as a washcloth. On 11/26/25 at 3:03 PM, V5 (CNA) stated they ran out of washcloths the prior week and she had to cut up a towel to use as a washcloth. On 11/26/25 at 3:24PM observed on C hall cart there was only 1 washcloth noted along with no towels. The cart on long A hall had only 1 washcloth.On 11/26/25 at 3:27PM there were no washcloths noted in the linen cart on the short A hall linen cart.On 11/26/25 at 3:33PM the shower room on A hall did not have any washcloths.On 11/26/25 at 3:41 PM, V9 (CNA) stated he has run out washcloths before and when they don't have washcloths, he will use a towel, or he will buy wipes with his own money and use those. On 12/1/25 at 11:34 AM, V6 (CNA) stated they sometimes run short on washcloths so he buys wipes himself and will use them to clean residents. On 12/02/25 at 10:44AM, V5 (CNA) stated that they are out of washcloths and towels and R35 was wanting a washcloth to be able to shave. V5 went outside to the laundry room to look for towels and washcloths. V5 said that she also went to the other halls to look for wash cloths and towels and couldn't find any washcloths at either place.On 12/02/25 at 10:50AM, R35 stated that he was just wanting a washcloth so he could shave. R35 stated that they weren't able to find a washcloth or a towel for him to be able to shave. R35 stated that he just wouldn't be able to shave now. R35's Face Sheet documents an admission date of 7/17/2025 with diagnoses including in part encounter for other orthopedic aftercare, wedge compression fracture of first lumbar vertebra, heart failure, chronic kidney disease, unspecified fall, difficulty in walking, displaced fracture of medial malleolus of left tibia, and pain. R35's MDS dated [DATE] document a BIMS of 15, indicating R35's cognition is intact. On 12/2/25 at 12:23 PM, V1 (Administrator) stated he has heard about supply issues but as soon as he hears about it, he will go to the store and buy what is needed. V1 stated linens are washed at an off-site facility and they are delivered every morning. V1 stated linens are delivered to the laundry house behind the facility and there is no formal process to get the linens to the floor for staff to use and it isn't any one person's responsibility to restock linen carts or the linen room after delivery. V1 stated he agrees there should be a process on who brings the laundry in, but anyone can get them as they need them. V1 stated he has extra towels and washcloths locked up that anyone can get from him at any time. V1 stated he has to lock up the extra towels and washcloths because if he doesn't the staff will hide them. V1 stated if a resident needs a washcloth, then it should be available. On 12/2/25 at 3:18 PM, V19 (CNA) stated she doesn't have any issues with supplies but sometimes will run out of washcloths. V19 stated that V1 just told her today that he had extra washcloths locked up and if she ran out again, she needed to let him know and he would get her some. 2. R1's Face Sheet documents an admission date of 10/16/2023 with diagnoses including in part multiple sclerosis, anxiety disorder, chronic pain syndrome, abnormal posture, repeated falls, muscle weakness, ataxic gait, and other fatigue. R1's Minimum Data Set, dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 08, indicating moderate cognitive impairment. R1's Care Plan documents R1 is at risk for falling. On 11/26/25 at 9:02 AM, R1 was lying in bed, and her call light was not in reach. One call light was on the wheelchair across the room, and the other call light was lying on the floor. R1 stated her call light is often out of reach. R1 was orientated to person, place, time, and situation during the interview. 3. R3's Face Sheet documents an admission date of 8/22/2018 with diagnose including in part Parkinson's disease, type 2 diabetes, long term use of insulin, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, and diaper dermatitis. R3's MDS dated [DATE] documents a BIMS of 15, indicating R3's cognition is intact. R3's Care Plan documents R3 is at risk for falls. On 11/25/25 at 2:41 PM, R3 was laying in his bed and stated he uses his call light when he can reach it. The call light was observed lying on the floor out of reach. R3 stated sometimes different workers move his call light away from him where he can't reach it when he needs it. On 11/25/25 at 4:14 PM, observed R3 lying in bed and his call light was on the floor out of reach. 4. R4's Face Sheet documents an admission date of 4/30/2024 with diagnoses including in part hypertension, type 2 diabetes, chronic kidney disease, morbid obesity, mild cognitive impairment of uncertain or unknown etiology, anxiety disorder, acquired absence of left leg below knee, history of falling, pain in left shoulder, and other chronic pain. R4's MDS dated [DATE] documents a BIMS of 15, indicating R4's cognition

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to prevent the verbal and physical abuse of a resident from staff for 1 of 7 residents (R7) reviewed for abuse in the sample of 44. This failure resulted in psycho/social harm to R7 having feelings of irritation, anger, and continued complaints of pain to her right shoulder.The findings include:R7's face sheet, dated 12/22/25 documents an admission date of 04/29/2021 with diagnoses in part of unspecified dementia, psychotic disturbance, mood disturbance, anxiety, primary arthritis, spondylosis with myelopathy or radiculopathy, malignant neoplasm of unspecified site of left breast, history of falling, and Vitamin D deficiency.R7's MDS (Minimum Data Set) dated 10/23/2025 documents in Section C a BIMS (Brief Interview for Mental Status) of 8 which indicates moderately impaired cognition. Section GG documents chair/bed to chair transfer as partial/moderate assistance.R7's Care Plan, edited 09/30/25 documents a problem of R7 is grieving due to recent loss of her son approaches for this problem include: Approach R7 in a calm manner and provide emotional support as needed. Another problem of Falls R7 is high risk for falls. R7 at risk for falling r/t (related to) history of falls visual acuity impairments, decreased safety awareness, impulsiveness with attempts to stand or self-transfers without assistance from staff leaning forward in chair with attempts to pick up objects. On 09/17/24 I slid out of my wheelchair in the hallway. I did not hit my head, and I do not have any obvious injury. On 1/22/25 I was observed sitting on the floor beside my bed. I have no apparent injury. On 03/27/25 I rolled out of bed when sleeping. I had shoulder pain, but it went away. On 07/29/25 I slid off of a pillow that was in the seat of my w/c (wheelchair). No injury. On 11/02/25 I was attempting to move from my w/c to the bed and slid to the floor. Approaches for this problem include: Keep assistive devices at bedside. Another problem area of R7 is considered at risk for abuse/neglect (per assessment) due to dx (diagnosis) of dementia/chronic pain/resistance of care/exit seeking approaches for this problem area include: address all complaints/concerns promptly with grievances policy and procedure, intervene if observing any peer-on peer conflict to avoid potential abusive situation. A facility document titled Long-Term Care Facility and IID-Serious Injury Incident report documents under general information: Incident Date 01/05/2025 with a time of incident of 0630 and a report date of 01/05/25. Resident #1 involved in Incident: R7 listed as victim. Staff #1 involved in the incident: V13 position CNA (Certified Nursing Assistant) , retained no, suspended yes, terminated no. Witness Name V16 (former Assistant Director of Nursing) and V49 (CNA). Detailed Incident Summary (Who, What, When, Where, Why) Resident #1 (R7) is a 95 y.o (year old) Fw/PMH (Female with a Past Medical History): dementia, CAD (Coronary Artery Disease), HTN (Hypertension), anxiety, insomnia, depression. Per the facility protocol, an investigation was conducted in response to an allegation of abuse involving resident #1 (R7). Per interview conducted with witness #2 (R49), resident approached witness #2 and staff during a conversation. Witness #1 (V16) stated that resident #1 stated she needed to be careful with that man staff asked resident not to interrupt and took resident #1 (R7) to room. Per staff member resident #1 (R7) referred to him as a druggie, loser, and a fool He did ask her to stop and took her to her room. While in the room staff member states that resident slapped him and scratched his face. Resident #1 then through a water pitcher at staff member striking him in the back of the head. Staff member left the room with no further incident. Staff member stated that he went outside to take a break following the incident. Staff member states that he did rush his care with resident #1, but he was never aggressive with the resident #1. Staff member states that he was frustrated with the resident's behavior. Multiple staff members did hear about the incident second hand. The PCP (Primary Care Physician, Administrator, ADON (Assistant Director of Nursing) and family were notified of the incident. An interview was conducted with the resident with ADON present. A skin assessment was completed with no findings by the ADON. Law enforcement notified of incident and investigation is ongoing with no current concerns. Facility investigation unsubstantiated with no findings of abuse. Resident #1 had no recollection of event on follow up interview. Dated 02/28/25 by V1 (Administrator) at 12:00PM. On 11/25/25 at 2:34 PM, R7 who was alert to person and place stated one day V1's (Administrator) son V13 (CNA) took her into her room and shut the door then grabbed her around her arms and chest from behind and squeezed her until it hurt then took her wheelchair away. R7 stated she told V1 and V1 took care of it. R7 stated she mentioned a couple times I ought to call the police but never did. R7 stated V13 never came back, she thinks he left town. On 12/17/25 at 3:45 PM, R7 who was alert to person and place stated she did have a man hurt her one time a while back and she doesn't know why he did it. R7 stated the man was V1's

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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 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

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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 0603 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from involuntary seclusion for 1 of 7 residents (R7) reviewed for abuse and neglect in the sample of 44. This failure resulted in R7 experiencing feelings of emotional distress and acts of crying out in fear from being placed into her bed without her wheelchair nearby leaving her with no means of transferring out of bed or mobility safely. The findings include: R7's face sheet, dated 12/22/25 documents an admission date of 04/29/2021 with diagnoses in part of unspecified dementia, psychotic disturbance, mood disturbance, anxiety, primary arthritis, spondylosis with myelopathy or radiculopathy, malignant neoplasm of unspecified site of left breast, history of falling, and Vitamin D deficiency.R7's MDS (Minimum Data Set) dated 10/23/2025 documents in Section C a BIMS (Brief Interview for Mental Status) of 8 which indicates moderately impaired cognition. Section GG documents chair/bed to chair transfer as partial/moderate assistance.R7's Care Plan, edited 09/30/25 documents a problem of R7 is grieving due to recent loss of her son approaches for this problem include: Approach R7 in a calm manner and provide emotional support as needed. Another problem of Falls R7 is high risk for falls. R7 at risk for falling r/t (related to) history of falls visual acuity impairments, decreased safety awareness, impulsiveness with attempts to stand or self-transfers without assistance from staff leaning forward in chair with attempts to pick up objects. On 09/17/24 I slid out of my wheelchair in the hallway. I did not hit my head, and I do not have any obvious injury. On 1/22/25 I was observed sitting on the floor beside my bed. I have no apparent injury. On 03/27/25 I rolled out of bed when sleeping. I had shoulder pain, but it went away. On 07/29/25 I slid off of a pillow that was in the seat of my w/c (wheelchair). No injury. On 11/02/25 I was attempting to move from my w/c to the bed and slid to the floor. Approaches for this problem include: Keep assistive devices at bedside. Another problem area of R7 is considered at risk for abuse/neglect (per assessment) due to dx (diagnosis) of dementia/chronic pain/resistance of care/exit seeking approaches for this problem area include: address all complaints/concerns promptly with grievances policy and procedure, intervene if observing any peer-on peer conflict to avoid potential abusive situation. A facility document titled Long-Term Care Facility and IID-Serious Injury Incident report documents under general information: Incident Date 01/05/2025 with a time of incident of 0630 and a report date of 01/05/25. Resident #1 involved in Incident: R7 listed as victim. Staff #1 involved in the incident: V13 position CNA (Certified Nursing Assistant) , retained no, suspended yes, terminated no. Witness Name V16 (former Assistant Director of Nursing) and V49 (CNA). Detailed Incident Summary (Who, What, When, Where, Why) Resident #1 (R7) is a 95 y.o (year old) Fw/PMH (Female with a Past Medical History): dementia, CAD (Coronary Artery Disease), HTN (Hypertension), anxiety, insomnia, depression. Per the facility protocol, an investigation was conducted in response to an allegation of abuse involving resident #1 (R7). Per interview conducted with witness #2 (R49), resident approached witness #2 and staff during a conversation. Witness #1 (V16) stated that resident #1 stated she needed to be careful with that man staff asked resident not to interrupt and took resident #1 (R7) to room. Per staff member resident #1 (R7) referred to him as a druggie, loser, and a fool He did ask her to stop and took her to her room. While in the room staff member states that resident slapped him and scratched his face. Resident #1 then through a water pitcher at staff member striking him in the back of the head. Staff member left the room with no further incident. Staff member stated that he went outside to take a break following the incident. Staff member states that he did rush his care with resident #1, but he was never aggressive with the resident #1. Staff member states that he was frustrated with the resident's behavior. Multiple staff members did hear about the incident second hand. The PCP (Primary Care Physician, Administrator, ADON (Assistant Director of Nursing) and family were notified of the incident. An interview was conducted with the resident with ADON present. A skin assessment was completed with no findings by the ADON. Law enforcement notified of incident and investigation is ongoing with no current concerns. Facility investigation unsubstantiated with no findings of abuse. Resident #1 had no recollection of event on follow up interview. Dated 02/28/25 by V1 (Administrator) at 12:00PM. On 11/25/25 at 2:34 PM, R7 who was alert to person and place stated one day V1's (Administrator) son V13 (CNA) took her into her room and shut the door then grabbed her around her arms and chest from behind and squeezed her until it hurt then took her wheelchair away. R7 stated she told V1 and V1 took care of it. R7 stated she mentioned a couple times I ought to call the police but never did. R7 stated V13 never came back, she thinks he left town. On 12/17/25 at 3:45 PM, R7 who was alert to person and place stated she did have a man hurt her one time a while back

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately report an allegation of staff to resident abuse to the administrator and failed to identify an incident of possible misappropriation of a resident's property and report the incident to the Illinois Department of Public Health for 2 of 7 residents (R2 and R7) reviewed for abuse and neglect in the sample of 44.Findings include:1. R7's face sheet, dated 12/22/25 documents an admission date of 04/29/2021 with diagnoses in part of unspecified dementia, psychotic disturbance, mood disturbance, anxiety, primary arthritis, spondylosis with myelopathy or radiculopathy, malignant neoplasm of unspecified site of left breast, history of falling, and Vitamin D deficiency.R7's MDS (Minimum Data Set) dated 10/23/2025 documents in Section C a BIMS (Brief Interview for Mental Status) of 8 which indicates moderately impaired cognition. Section GG documents chair/bed to chair transfer as partial/moderate assistance.R7's Care Plan, edited 09/30/25 documents a problem of R7 is grieving due to recent loss of her son approaches for this problem include: Approach R7 in a calm manner and provide emotional support as needed. Another problem area of R7 is considered at risk for abuse/neglect (per assessment) due to dx (diagnosis) of dementia/chronic pain/resistance of care/exit seeking approaches for this problem area include: address all complaints/concerns promptly with grievances policy and procedure, intervene if observing any peer-on peer conflict to avoid potential abusive situation. On 11/25/25 at 2:34 PM, R7 who was alert to person and place stated V1's (Administrator) son V13 (Certified Nurse Assistant) took her into her room and shut the door then grabbed her around her arms and chest from behind and squeezed her until it hurt then took her wheelchair away. R7 stated she told V1 and V1 took care of it. R7 stated she mentioned a couple times I ought to call the police but never did. R7 stated V13 never came back, she thinks he left town. On 12/17/25 at 3:45 PM, R7 who was alert to person and place stated she did have a man hurt her one time a while back and she doesn't know why he did it. R7 stated the man was V1's son V13. R7 stated V1's son took her into the room in her wheelchair and got behind her and wrapped his arms around her and squeezed really hard until it hurt. R7 stated she felt like he broke her arms. R7 stated she doesn't remember what he said to her or why he did it, but she remembers he hurt her and to this day her right shoulder hurts. R7 stated after V13 let go of her arms he took her wheelchair away. R7 stated she doesn't remember how she got her wheelchair back. R7 stated that it scared her, and she didn't know what to do. On 12/11/25 at 1:08 PM, V13 (former CNA) stated R7 called him a drug addict and multiple other things and he got tired of being called that. V13 stated, I didn't do anything to hurt that woman, I shut the door and I apologized. V13 stated he took R7 back to her room because it was late and maybe she was acting up because she was tired. V13 stated he took her into her room to get her ready for bed then R7 came out again so he took her back into her room and then she threw water at me and smacked me in the face and chest, you know like what old ladies do. V13 stated he walked out of the room when R7 started hitting him but he doesn't remember if she was in her bed, in her wheelchair, or if he was in the middle of transferring her into her bed. V13 stated at one point he got down to eye level with R7 and was trying to talk to her. V13 stated he might have raised his voice at her in frustration during this but then he left the room in frustration and took the wheelchair. V13 stated he doesn't remember who gave R7 the wheelchair back. V13 stated, I never harmed that woman, I was just over exaggerated on the story in the morning. V13 stated at the end of the day that woman was down on the other hallway upset most of the night. V13 said that some people know how to handle her better than he does. V13 stated he tried to help R7 go to bed, and she got up immediately and she was very frustrated with him and it was unclear to him why. V13 stated he is one person to 20 residents, so he didn't want his clothes wet to take care of all the other residents. V13 stated, the other staff were appeasing her and giving her crap that I can't give her. V13 stated he already told her she couldn't have a soda, and the others gave it to her on the other hall. V13 stated R7 will go to the other parts of the building and find someone that will give her soda to make her happy. V13 stated he doesn't have the money to buy residents soda, and the residents can't expect the same treatment from every CNA. V13 stated he didn't have any conversation with R7 after the incident. V13 stated there were call ins and they were short 2 CNA's (Certified Nurse Assistants) so he was very busy and doesn't remember if she came back to her room that night. V13 stated he doesn't remember who called him and asked him what happened. On 12/13/25 at 3:19PM, V14 (Licensed Practical Nurse/LPN) stated he was on A wing passing meds the night of the incident with V13 and R7 and he was by room [ROOM NUMBER] because he had just come out from there passing

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Helia Healthcare of Energy	210 East College Energy, IL 62933

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly and immediately investigate allegations of abuse and potential theft, failed to prevent further potential abuse/neglect from occurring while allowing staff to continue to have direct care with residents after allegations were made, and failed to conclude willful intent occurred involving a staff to resident altercation for 2 of 7 (R2 and R7) residents reviewed for abuse in a sample of 44. Findings include:1. R7's face sheet, dated 12/22/25 documents a admission date of 04/29/2021 with diagnoses in part of unspecified dementia, psychotic disturbance, mood disturbance, anxiety, primary arthritis, spondylosis with myelopathy or radiculopathy, malignant neoplasm of unspecified site of left breast, history of falling, and Vitamin D deficiency.R7's MDS (Minimum Data Set) dated 10/23/2025 documents in Section C a BIMS (Brief Interview for Mental Status) of 8 which indicates moderately impaired cognition. Section GG documents chair/bed to chair transfer as partial/moderate assistance.R7's Care Plan, edited 09/30/25 documents a problem of R7 is grieving due to recent loss of her son approaches for this problem include: Approach R7 in a calm manner and provide emotional support as needed. Another problem area of R7 is considered at risk for abuse/neglect (per assessment) due to dx (diagnosis) of dementia/chronic pain/resistance of care/exit seeking approaches for this problem area include: address all complaints/concerns promptly with grievances policy and procedure, intervene if observing any peer-on peer conflict to avoid potential abusive situation.A facility document titled Long-Term Care Facility and IID-Serious Injury Incident report documents under general information: Incident Date 01/05/2025 with a time of incident of 0630 and a report date of 01/05/25. Resident #1 involved in Incident: R7 listed as victim. Staff #1 involved in the incident: V13 position CNA (Certified Nursing Assistant) , retained no, suspended yes, terminated no. Witness Name V16 (former Assistant Director of Nursing) and V49 (CNA). Detailed Incident Summary (Who, What, When, Where, Why) Resident #1 (R7) is a 95 y.o (year old) Fw/PMH (Female with a Past Medical History): dementia, CAD (Coronary Artery Disease), HTN (Hypertension), anxiety, insomnia, depression. Per the facility protocol, an investigation was conducted in response to an allegation of abuse involving resident #1 (R7). Per interview conducted with witness #2 (R49), resident approached witness #2 and staff during a conversation. Witness #1 (V16) stated that resident #1 stated she needed to be careful with that man staff asked resident not to interrupt and took resident #1 (R7) to room. Per staff member resident #1 (R7) referred to him as a druggie, loser, and a fool He did ask her to stop and took her to her room. While in the room staff member states that resident slapped him and scratched his face. Resident #1 then through a water pitcher at staff member striking him in the back of the head. Staff member left the room with no further incident. Staff member stated that he went outside to take a break following the incident. Staff member states that he did rush his care with resident #1, but he was never aggressive with the resident #1. Staff member states that he was frustrated with the resident's behavior. Multiple staff members did hear about the incident second hand. The PCP (Primary Care Physician, Administrator, ADON (Assistant Director of Nursing) and family were notified of the incident. An interview was conducted with the resident with ADON present. A skin assessment was completed with no findings by the ADON. Law enforcement notified of incident and investigation is ongoing with no current concerns. Facility investigation unsubstantiated with no findings of abuse. Resident #1 had no recollection of event on follow up interview. Dated 02/28/25 by V1 (Administrator) at 12:00PM. On 11/25/25 at 2:34 PM, R7 who was alert to person and place stated one day V1's (Administrator) son V13 (CNA) took her into her room and shut the door then grabbed her around her arms and chest from behind and squeezed her until it hurt then took her wheelchair away. R7 stated she told V1 and V1 took care of it. R7 stated she mentioned a couple times I ought to call the police but never did. R7 stated V13 never came back, she thinks he left town. On 12/17/25 at 3:45 PM, R7 who was alert to person and place stated she did have a man hurt her one time a while back and she doesn't know why he did it. R7 stated the man was V1's son V13. R7 stated V1's son took her into the room in her wheelchair and got behind her and wrapped his arms around her and squeezed really hard until it hurt. R7 stated she felt like he broke her arms. R7 stated she doesn't remember what he said to her or why he did it, but she remembers he hurt her and to this day her right shoulder hurts. R7 stated after V13 let go of her arms he took her wheelchair away. R7 stated she doesn't remember how she got her wheelchair back. R7 stated that it scared her, and she didn't know what to do. At that time observed R7 trying to show she couldn't reach across her body with her right arm and when she moved her right arm across her body to

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a dependent resident timely ADL (Activities of Daily Living) assistance with transfers for 1 of 6 residents (R1) reviewed for ADL assistance in the sample of 44.Findings include:R1's Face Sheet documents an admission date of 10/16/2023 with diagnoses including: multiple sclerosis, anxiety disorder, chronic pain syndrome, abnormal posture, repeated falls, muscle weakness, ataxic gait, and other fatigue.R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 08, indicating R1 has moderate cognitive impairment. Section GG of the dame MDS documents R1 is dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for chair/bed to chair transfers.R1's Physician Order Report dated 11/2/25-12/2/25 documents an order for mechanical lift for transfers dated 10/16/23.R1's Care Plan documents R1 is dependent for transfers, R1 uses mechanical lift for all transfers with a start date of 10/3/25. On 11/26/25 at 8:00 AM there was a plate of untouched food sitting at the table in the dining room with no cover on it and no resident was near it. This surveyor asked V7 (Certified Nursing Assistant/CNA) whose food it was, and he stated it was R1's but she wasn't out of bed yet because he needed help to get her up and they hadn't had time yet.On 11/26/25 at 8:25 AM, V5 (Certified Nursing Assistant/CNA) took the plate of food off the table and took it to R1's room to assist her with eating.On 11/26/25 at 8:28 AM, R1 was lying in bed. R1 stated she wanted to get up for breakfast, but the CNA told her she couldn't get her up because there wasn't anyone to help her since she was a mechanical lift transfer. R1 stated she doesn't like eating in her bed, she likes going to the dining room for meals. R1 was orientated to person, place, time, and situation during interview.On 11/26/25 at 8:32 AM, V5 (CNA) stated she was told when she arrived at her shift at 8am that they didn't have enough staff to get R1 up since she was a mechanical lift.On 11/26/25 at 2:34 PM, V7 (CNA) stated night shift doesn't get any 2 assist residents up in the morning and he is the only CNA on the floor from 6am-8am so he must find someone to help him get R1 up since she is a mechanical lift. V7 stated he didn't get R1 up today because she is a 2 person assist, and he would rather get up the other 13 residents that are a 1 assist than get up 1 resident that needs 2 staff to help.On 12/2/25 at 11:22 AM, V2 (Director of Nursing) stated no resident should be left in bed because they are a 2 person assist. V2 stated there are plenty of staff in the building to help, including herself.On 12/2/25 at 12:23 PM, V1 (Administrator) stated he is not aware of staff unable to get mechanical lift residents up due to not having enough staff to help, they should ask someone in the building to help. V1 stated there is always someone in the building to help.On 12/18/25 at 9:10 AM, V2 stated all mechanical lifts should be performed with 2 qualified staff.A facility policy titled Mechanical Lift dated October 2017 documents under Policy: The mechanical lift may be used to lift and move a resident with limited ability during transfer while providing safety and security for residents and nursing personnel.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer/apply pain medications as ordered for 1 of 3 residents (R19) reviewed for pain management in a sample of 44. This failure resulted in R19 experiencing pain with the treatment application to R19's leg wounds.The findings include: R19's Face Sheet documents an admission date of 9/26/25 with diagnoses including: cellulitis of right lower limb, weakness, depression, and other specified hearing loss bilateral.R19's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 07, indicating R19 has severe cognitive impairment. Section J, Health Conditions, documents that R19 experiences pain or hurting frequently.R19's Care Plan documents that R19 has impaired skin integrity related to venous insufficiency and R19 has pain/risk for pain with a start date of 9/26/25 with documented interventions including administer medications, monitor and record effectiveness, and report adverse side effects.R19's Wound Evaluation and Management Summary Report dated 12/10/25 documents that R19 has the following wounds: Venous wound of the right leg with a wound size of 13.6 cm (Centimeters) length x 16.8 cm width x 0.3cm depth , skin tear of the right dorsal foot wound size of 1.3 cm in length x 1.4 cm width x 0.5 cm in depth, arterial wound of the right ankle with a wound size of 2.7 cm length x 2.7 cm in width x 0.4 cm in depth, non-pressure wound of the right medial foot with a wound size of 1.3 cm length x 2.4 cm in width x 0.3 cm in depth, and skin tear to the right, posterior ankle with a wound size of 12 cm in length x 5 cm in width x 0.3 cm in depth.R19's Physician Order Report dated 11/15/2025-12/15/2025 documents and order for Lidocaine cream 4% topical, apply to right lower extremity wounds prior to wound care/treatment change once a day with a start date of 11/17/25 and an end dated labeled open ended, an order for pain assessment every shift with a start date of 10/06/25 with an end date labeled open ended, and an order for hydrocodone-acetaminophen tablet 5-325mg amt (Amount) 1 tablet twice a day PRN (as needed) with a start date of 09/26/25 and an end date labeled open ended. R19's Pain-MDS focused assessment dated [DATE] documents: Pain received schedule pain med regimen: No; Pain management: Received PRN (as needed) pain meds or offered and declined: Yes; Received non-medication interventions: Yes; Should pain assessment interview be conducted: Yes; Res (resident) have you had pain or hurting at any time in the last 5 days? Yes; Res (resident) How much of the time have you experienced pain or hurting over the last 5 days? Occasionally; Res (resident) Over the past 5 days, how much of the time has pain made it hard for you to sleep at night? Rarely or not at all; Res (resident) Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain? Rarely or not at all; Resident Over the past 5 days, how often have you limited your day-to-day activities? Occasionally; and Resident please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine: 4.R19's Medication Administration Record (MAR) for December 2025 documents: Hydrocodone-Acetaminophen 5-325mg 1 tablet PRN (As Needed) twice a day. Administered on 12/02/25 at 8:45PM for pain, 12/04/25 at 12:28AM for pain, 12/04/25 at 9:40AM for pain, 12/05/25 at 10:52PM for pain, 12/08/25 12:44AM for pain, 12/08/25 10:29PM for pain, 12/09/25 10:31AM for pain, 12/09/25 11:11PM for pain, 12/10/25 10:31AM for pain, 12/10/25 7:40PM pain 4/10 RLE (Right Lower Extremity), 12/12/25 12:50AM for pain 7/10 for RLE, 12/12/25 7:34PM for pain, 12/13/25 7:33PM for pain, 12/15/25 12:54Am for pain, 12/17/25 at 9:47AM for pain 12/21/25 at 12:32AM for pain, 12/21/25 11:40PM for pain 4/10 RLE. The same MAR documents the order for Lidocaine cream 4% topical apply to right lower extremity wounds prior to wound care/treatment change from 6:30PM to 6:30AM was administered on the following dates: 12/01/25, 12/02/25, 12/03/25, 12/04/25, 12/05/26, 12/06/25, 12/07/25, 12/08/25, 12/09/25, 12/10/25, 12/11/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25, 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, and 12/21/25. On 12/08/25 at 11:41 PM, V37 (License Practical Nurse) was observed providing wound treatment on R19 wounds of the right leg and foot. Observed old dressing which was saturated with large amounts of yellowish-green drainage to entire dressing. Topical lidocaine was not observed to be applied during this observation. R19 was observed multiple times throughout the procedure grimacing, grabbing her leg, and saying ouch. Wounds extend to most of R19 lower right leg from front to the back with what appears to be a depth of around 0.25 to 0.5 cm in depth. The area to the back of the right leg around the ankle/heel area looks to have a large amount of slough and possible muscle exposure.On 12/08/25 at 1:30 PM, R19 stated that there have been times when she has not gotten her treatment done to her right leg. R19 stated the nurses won't do it for a couple of days

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure sufficient staff to meet the needs of the residents timely. This has the potential to affect all 73 residents currently residing at the facility. Findings include:1. R1's Face Sheet documents an admission date of 10/16/2023 with diagnoses including in part multiple sclerosis, anxiety disorder, chronic pain syndrome, abnormal posture, repeated falls, muscle weakness, ataxic gait, and other fatigue. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 08, indicating moderate cognitive impairment.R1's Physician Order Report dated 11/2/25-12/2/25 documents mechanical lift for transfers. R1's Care Plan documents R1 is dependent for transfers, R1 uses mechanical lift for all transfers. On 11/26/25 at 8:28 AM, R1 was lying in bed. R1 stated she wanted to get up for breakfast, but the CNA (Certified Nursing Assistant) told her she couldn't get her up because there wasn't anyone to help her since she was a mechanical lift. R1 stated she doesn't like eating in her bed, she likes going to the dining room for meals. R1 was orientated to person, place, time, and situation during interview. On 11/26/25 at 8:32 AM, V5 (CNA) stated she was told when she arrived at her shift at 8am that they didn't have enough staff to get R1 up since she was a mechanical lift. On 11/26/25 at 2:34 PM, V7 (CNA) stated night shift doesn't get any 2 person assist up in the morning and he is the only CNA on the floor from 6am-8am so he must find someone to help him get R1 up since she is a mechanical lift. V7 stated he didn't get R1 up today because she is a 2 person assist, and he would rather get up the other 13 residents that are a 1 assist then get up 1 resident that needs 2 staff to help. On 12/2/25 at 11:22 AM, V2 (Director of Nursing) stated no resident should be left in bed because they are a 2 person assist. V2 stated there are plenty of staff in the building to help, including herself. On 12/2/25 at 12:23 PM, V1 (Administrator) stated he is not aware of staff unable to get mechanical lift residents up due to not having enough staff to help, they should ask someone in the building to help. V1 stated there is always someone in the building to help. 2. R38's Face Sheet documents an admission date of 10/18/2023 with diagnoses including in part pain in right foot, hypertension, and tobacco use. R38's MDS dated [DATE] documents a BIMS of 15, indicating R28's cognition is intact.On 11/26/25 at 9:14 AM, R38 stated it can take 30 minutes or more to get his call light answered at times. 3. R27's Face Sheet documents an admission date of 10/17/2023 with diagnoses including in part generalized arthritis. R27's MDS dated [DATE] documents a BIMS of 10, indicating R27's cognition is moderately impaired.On 11/26/25 at 9:16 AM, R27 stated she feels like they could really use more staff, especially nighttime they need staff the most. 4. R30's Face Sheet documents an admission date of 9/30.2025 with diagnoses including in part pain in thoracic spine, nausea with vomiting, dizziness and giddiness, weakness, and other chronic pain. R30's MDS dated [DATE] documents a BIMS of 15, indicating R30's cognition is intact.On 11/26/25 at 9:30, AM, R30 stated she thinks they could use more help on all shifts. R30 stated sometimes when you need assistance you might have to wait a while for help. 5. R4's Face Sheet documents an admission date of 4/30/2024 with diagnoses including in part hypertension, type 2 diabetes, chronic kidney disease, morbid obesity, mild cognitive impairment of uncertain or unknown etiology, anxiety disorder, acquired absence of left leg below knee, history of falling, pain in left shoulder, and other chronic pain. R4's MDS dated [DATE] documents a BIMS of 15, indicating R4's cognition is intactOn 11/26/25 at 9:45 AM, R4 stated his call light can be a long wait at times, sometimes up to an hour and it is usually worse on Saturdays and Sundays. R4 stated he asked for a cup of ice water one night recently and he waited about 4 hours before he got it. On 12/01/25 at 3:06 PM, V28 (Cook) stated he has seen the CNA's not getting all the residents up for meals. V8 stated a lot of times they don't have enough staff to be able to get all the resident up for meals. On 12/04/25 at 5:18 PM, V32 (License Practical Nurse) stated her last day was in October of 2025. V32 stated they were short of staff often. V32 stated they had times when there was only 2 CNA's in the entire building and management would get mad when we would tell them that we have no staff. V32 stated administration would send out a group text message trying to get someone in to work, they would offer bonus to try and get someone to come in but most of the time they weren't able to get anyone in to work. V32 stated a lot of the time they didn't have any management come in to help, they would just work short. On 12/03/25 at 2:19 PM, V21 (Licensed Practical Nurse) stated she has witnessed where they couldn't get all the residents up or put them back in bed because they only had 1 CNA and 1 nurse on the unit. V21 stated the nurse was busy doing medication pass and couldn't help the CNA out to lay down the residents or get them up. On 12/08/25 at 10:32 AM, V21

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all staff have the appropriate competencies and skill sets to provide care and meet the residents' needs. This failure has the potential to effect all 73 residents living in the facility.The findings include: On [DATE] at 9:45 AM, V20 (Certified Nurse Assistant/CNA) stated this past weekend there was a CNA that was not certified working as a CNA, and she was let go on Monday by V1 (Administrator).On [DATE] at 10:06 AM, V1 (Administrator/ADM) stated the BOM (Business Office Manager) checks the CNA registry for their credentials prior to them working. V1 stated V46 (Nurse Assistant/NA) was hired and worked as a CNA but they later found out she never showed up for her certification test, so she is not a Certified Nursing Assistant. V1 stated they have a NA policy, but he is unsure what job duties she actually performed while on the job. V1 stated V46 was hired on [DATE].On [DATE] at 11:30AM, V1 said that they did have a CNA (V46) that was working at the facility he thought she was a CNA. V1 said that they did check the CNA registry, and it said that V46 was eligible for hire, and he said that it wasn't until recently he checked the registry and saw that under her test it said NS. V1 said that he didn't know what NS meant so he emailed the registry to ask them what the NS meant next to testing. V1 said that the CNA registry emailed him back and told him that the NS meant that V46 was a no show to take the CNA exam. V1 said that she had 120 days to take her test and work as a NA with another CNA. V1 said that he thinks the 120 days was up around [DATE]. V1 said that he doesn't know if she worked outside of her qualifications. V1 said they did a lot of hiring at the facility recently. V1 said that she no longer works at the facility now.On [DATE] at 10:10AM, V30 (CNA) stated they had a CNA V46 who was working on night shift who was not certified.On [DATE] at 09:13 AM, V1 provided hire date of [DATE] and a termination date of [DATE] for V46.On [DATE] at 9:32 AM, V3 (Assistant Director of Nursing/ADON) stated V46 (NA) worked primarily on the ARCH unit but she floated so probably would have worked on all hallways in the whole building. V3 stated she heard a rumor that V46 didn't have an active CNA certification, so she went straight to V1 and told him, and she did not work again after they found out she didn't have a current certification. V3 stated V46 was hired as a CNA so she could have provided care as a CNA outside of the NA policy, but she doesn't know for sure because she worked midnights, and she wasn't ever in the building when she was working.On [DATE] at 9:56 AM, V46 (NA) stated she started at the facility the week prior to Thanksgiving this year and she worked as a full CNA. V46 stated when she was hired V2 (DON) knew she hadn't tested yet. V46 stated V2 told her to schedule it as soon as she could. V46 stated she finished CNA school in May of 2025 and her test is scheduled for [DATE]. V46 stated when she interviewed with V2 (DON) she told her she hadn't taken her certification test yet but she really wanted the job. V46 stated V2 hired her on the spot during her interview with the intention she would take her test as soon as she could. V46 stated V2 told her she was okay with her working without her certification for a little while until she could take her test. V46 stated she worked all over the building, she would go where she was needed.The facility document titled Certified Nursing Assistant Job Description documents job summary as The overall purpose of the Certified Nursing Assistant position is to provide each of the assigned residents with routine daily nursing care and services in accordance with the residents' plan of care. Education and Experience Requirements: The Certified Nursing Assistant must have the following: State certification as a Certified Nursing Assistant, CPR (Cardiopulmonary Resuscitation) Certification preferred, ability to read, write, and speak the English language, no disqualifying criminal offenses as defined by regulatory guidelines.The midnight census report dated [DATE] documents there are 73 residents living in the facility.

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	146045	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Healthcare of Energy	210 East College Energy, IL 62933

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to acquire medication from the pharmacy and administer and document medications as ordered for 4 of 13 residents (R2, R3, R17, R19) reviewed for pharmacy services in a sample of 44.Findings include:1. R3's Face Sheet documents an admission date of 8/22/2018 with diagnoses including: Parkinson's disease, type 2 diabetes, long term use of insulin, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, and diaper dermatitis.R3's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R3's cognition is intact.R3's Care Plan documents a problem category of pressure ulcer/injury. Impaired skin integrity related to wound healing with risk of inadequate fluid and nutritional intake as evidenced by delayed wound healing, poor oral intake, and signs of dehydration with a start date of 2/12/25. R3's Physician Order Report dated 11/2/25-12/2/25 documents an order to place on enhanced barrier precautions per guidelines with a start date of 4/1/24. Same report documents an order for silver sulfadiazine cream topical, cleanse the area to the left upper buttock with wound cleanser or normal saline, apply Silvadene cream, collagen powder, calcium alginate, and dry dressing daily with a start date of 11/5/25.On 12/8/25 at 11:45 PM, wound treatment for R3 was observed. V25 (Registered Nurse/RN) mixed collagen and silver sulfadiazine cream that had another resident's name on it and had an expiration date of 9/30/2025. This surveyor asked V25 if the cream belonged to R3, and she stated she doesn't know where his is, so she is going to use the cream that belongs to a different resident since she doesn't use it anymore.2. R17's Face Sheet documents an admission date of 10/16/2023 with diagnoses including: Alzheimer's disease, type 2 diabetes, protein-calorie malnutrition, pain, cellulitis of unspecified part of limb, and need for assistance with personal care.R17's MDS dated [DATE] documents a BIMS score of 04, indicating R17 has severe cognitive impairment.R17's Care Plan documents R17 is at risk for impaired skin integrity related to incontinent of bowel and bladder and decreased mobility and R17 has pain/risk for pain with a start date of 11/24/23.R17's Physician Order Report dated 11/15/2025-12/15/2025 documents orders for silver sulfadiazine cream topical and clotrimazole cream topical, special instructions: Cleanse the wound to the right abdomen with normal saline or wound cleanser, apply silver sulfadiazine cream, clotrimazole, collagen powder, calcium alginate, and dry dressing daily, once a day, 06:30 PM - 06:30 AM with a start date of 9/17/2025 and an end date labeled open ended, Metronidazole tablet 500 mg and betadine solution topical, special instructions: cleanse the wound to the right third toe with wound cleanser or normal saline, apply betadine, crushed metronidazole, calcium alginate, and dry dressing daily with a start date of 11/3/2025 and an end date labeled open ended, and Povidone-iodine solution topical, special instructions: start betadine, calcium alginate and gauze wrap for the whole foot daily, once a day, 07:00 PM - 10:00 PM with a start date of 12/7/2025 and an end date labeled open ended.On 12/9/25 at 12:09 AM, wound care for R17 was observed. V25 (Registered Nurse/RN) had to go to another unit to find collagen. V25 mixed collagen and silver sulfadiazine cream together. The tub of silver sulfadiazine cream did not have a name on it, V25 stated she didn't know who it belonged to because it doesn't have a name on it, but she doesn't know where R17's cream is, so she is going to use it.3. R19's Face Sheet documents an admission date of 9/26/25 with diagnoses including: cellulitis of right lower limb, weakness, depression, and other specified hearing loss bilateral.R19's MDS dated [DATE] documents a BIMS score of 07, indicating R19 has severe cognitive impairment.R19's Care Plan documents R19 has impaired skin integrity related to venous insufficiency with a start date of 9/26/25.R19's Physician Order Report dated 11/15/2025-12/15/2025 documents orders for silver sulfadiazine cream topical, cleanse the wound to the right medial foot, top of right foot, right leg, right posterior leg, and right ankle with normal saline or wound cleanser, apply silver sulfadiazine cream, collagen powder, calcium alginate, gauze roll and secure with tape with a start date of 10/30/2025 and an end date labeled open ended and Lidocaine cream 4% topical, apply to right lower extremity wounds prior to wound care/treatment change once a day with a start date of 11/17/25 and an end dated labeled open ended.On 12/08/25 at 1:30 PM, R19 stated that there have been times when she has not gotten her treatment done to her right leg. R19 stated the nurses won't do it for a couple of days. R19 stated they have told her they have ran out of the medicine they put on her wounds on her right leg before. R19 stated she couldn't remember how many times they have ran out of treatment supplies for her right leg.On 12/03/25 at 2:19 PM, V21 (LPN) stated they run out of wound supplies like prescription creams and medication for wounds at times, and she

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to administrated medications as prescribed by a physician for 2 of 13 (R11, R12) residents reviewed for medication administration in a sample 44. Findings includeOn 12/1/25 at 11:10 AM, the medication administration observation with V15 (Licensed Practical Nurse/LPN) began. V15 opened the top drawer to her medication cart and there were 2 medicine cups of pills with R11 and R12's names on them. This nurse asked V15 what the pills in the cup were and she stated those are R11 and R12's morning pills. V15 stated she tried to give R11 and R12 their pills and they wouldn't wake up, so she just put the pill cup with their pills in it in the drawer and was going to try to administer them later, but stated she forgot. V15 stated she hasn't tried to give the pills a second time yet. At this time, V2 (Director of Nursing/DON) walked by and saw the pills and stated, pills should not be popped unless they are given at that time, and they should not be placed in cups and left in the medicine cart. V2 took the pill cups and stated she was going to destroy them in the drug buster in her office.1. R11's Face Sheet documents an admission date of 6/6/23 with diagnoses including: anemia, vitamin D deficiency, hypokalemia, psychotic disorder with delusions, hydronephrosis, neuromuscular dysfunction of bladder, retention of urine, dementia, hypertensive heart and chronic kidney disease without failure, type 2 diabetes mellitus, chronic kidney disease stage 3, and history of falling.R11's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 4, indicating R4's cognition is severely impaired.R11's Medication Administration Record (MAR) dated 12/1/25-12/4/25 documents R11 was supposed to receive Eliquis, ferrous sulfate, Macrobid, metoprolol tartrate, MiraLAX, omeprazole, oxybutynin chloride, and potassium chloride every morning.2. R12's Face Sheet documents an admission date of 9/30/21 with diagnoses including: malignant neoplasm of right lower lobe of lung or bronchus, shortness of breath, Alzheimer's disease, atherosclerosis of coronary artery bypass graft, hypertensive heart and chronic kidney disease with heart failure, hypertension, chronic systolic heart failure, chronic kidney disease, edema, and pain.R12's MDS dated [DATE] documents a BIMS score of 14, indicating R12's cognition is intact.R12's MAR dated 12/1/25-12/4/25 documents R12 was supposed to receive 4oz Hi calorie supplement, amlodipine, aspirin, celexa, cranberry extract, vitamin B-12, daily multivitamin, Depakote sprinkles, and furosemide every morning.On 12/02/25 at 11:11 AM, V2 (Director of Nursing) stated when the surveyor was observing V15 start medication pass on 12/1/25 there were two cups with pills already popped out in them that belonged to R11 and R12. V2 stated she brought the medications into her office and put them in the drug buster. V2 stated if medications are not given at all then it would be considered a medication error, but she thinks late medication are not considered a medication error.On 12/02/25 at 2:10 PM, the medications from R11 and R12's MAR that were documented as given on 12/1/25 in the morning were went over with V15 and V15 stated she did not give any of those medications, but she documented she gave them to both R11 and R12. V15 stated she had R11 and R12's pills popped and in a medication cup with their name on it in the medication cart. V15 stated when she was passing morning medications, she went into R11's room to give him his medication and he was asleep. V15 stated she never gave R11 his medication form that morning even though she signed it off in the electronic medical record as given. V15 stated R11 did not refuse his medications he was just asleep when she went in there and she couldn't get him to wake up and she forget to go back and try again. V15 stated the same thing happened with R12 when she went into his room to give him his medications that she had already popped and placed in a medication cup and he was sleeping, and she didn't want to wake him up. V15 stated R12 did not refuse his medications either. V15 stated she signed off R12's medications even though he never received them. V15 stated she should have made a note in in R11 and R12's chart regarding the missed medication but she forgot to. V15 stated she normally gives all the residents their medications and isn't normally late like this, but she was very busy. V15 stated she usually works night shift, so she is not familiar with when residents wake up and how they like to take their medications during the day. V15 stated she did not call and notify the physician or nurse practitioner to notify them about R11 and R12 not getting their morning medications on 12/1/25.On 12/18/25 at 9:10 AM, V2 stated she considers not giving medications a medication error. V2 said that cardiac medications, blood thinners, insulin and antibiotics she considers significant medication errors.On 12/2/25 at 12:23 PM, V1 (Administrator) stated medications should not be popped and left in a medication cup in the medication cart. V1 stated if a medication is not given it should be considered a medication error. V1 stated a medication

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to use accurately labeled medication/cream, use cream that was not expired, and lock the medication and wound treatment carts. This failure has the ability to affect all 73 residents in the facility. Findings include:1. R17's Face Sheet documents an admission date of [DATE] with diagnoses including: Alzheimer's disease, type 2 diabetes, protein-calorie malnutrition, pain, cellulitis of unspecified part of limb, and need for assistance with personal care.R17's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 04, indicating R17 has severe cognitive impairment.R17's Care Plan documents R17 is at risk for impaired skin integrity related to incontinent of bowel and bladder and decreased mobility and R17 has pain/risk for pain with a start date of [DATE].R17's Physician Order Report dated [DATE]-[DATE] documents orders for silver sulfadiazine cream topical and clotrimazole cream topical, special instructions: Cleanse the wound to the right abdomen with normal saline or wound cleanser, apply silver sulfadiazine cream, clotrimazole, collagen powder, calcium alginate, and dry dressing daily, once a day, 06:30 PM - 06:30 AM with a start date of [DATE] and an end date labeled open ended, Metronidazole tablet 500 mg and betadine solution topical, special instructions: cleanse the wound to the right third toe with wound cleanser or normal saline, apply betadine, crushed metronidazole, calcium alginate, and dry dressing daily with a start date of [DATE] and an end date labeled open ended, and Povidone-iodine solution topical, special instructions: start betadine, calcium alginate and gauze wrap for the whole foot daily, once a day, 07:00 PM - 10:00 PM with a start date of [DATE] and an end date labeled open ended. On [DATE] at 12:09 AM, wound care for R17 was observed. V25 (Registered Nurse/RN) had to go to another unit to find collagen. V25 mixed collagen and silver sulfadiazine cream together. The tub of silver sulfadiazine cream did not have a name on it, V25 stated she didn't know who it belonged to because it doesn't have a name on it, but she doesn't know where her cream is, so she is going to use it.2. R3's Face Sheet documents an admission date of [DATE] with diagnose including: Parkinson's disease, type 2 diabetes, long term use of insulin, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, and diaper dermatitis.R3's MDS dated [DATE] documents a BIMS score of 15, indicating R3's cognition is intact.R3's Care Plan documents a problem category of pressure ulcer/injury. Impaired skin integrity related to wound healing with risk of inadequate fluid and nutritional intake as evidenced by delayed wound healing, poor oral intake, and signs of dehydration with a start date of [DATE].R3's Physician Order Report dated [DATE]-[DATE] documents an order for silver sulfadiazine cream topical, cleanse the area to the left upper buttock with wound cleanser or normal saline, apply Silvadene cream, collagen powder, calcium alginate, and dry dressing daily with a start date of [DATE].On [DATE] at 11:45 PM, wound treatment for R3 was observed. V25 (Registered Nurse/RN) mixed collagen and silver sulfadiazine cream that had another resident's name on it and had an expiration date of [DATE]. This surveyor asked V25 if the cream belonged to R3, and she stated she doesn't know where his is, so she is going to use the cream that belongs to a different resident since she doesn't use it anymore. This surveyor asked V25 what the expiration date of the silver sulfadiazine cream is, and she stated [DATE]. On [DATE] at 12:33 AM, V25 stated sometimes she will use other residents supplies if she can't find the correct supplies. V25 stated she probably shouldn't have used expired silver sulfadiazine cream on R3.On [DATE] at 10:55 PM, a cup of white cream with a spoon on top of the treatment cart for A Wing, Long Hall was observed. A tube of Nystatin on top of treatment cart was also observed with no nurse in the area. The treatment cart was unlocked.On [DATE] at 10:58 PM, the medication cart for A Wing, Long Hall was observed and was unlocked with the top drawer open slightly, with no nurse in the area. 2 Certified Nursing Assistants were observed working on the hall where the treatment cart was located. On [DATE] at 11:09 PM, the medication cart for A Wing, Short Hall was observed to be unlocked, with no nurse observed on the hallway. There were 2 CNA's observed working on the hallway where the medication cart was observed.On [DATE] at 11:10 PM, the medication cart for C Wing, East Hall was observed to be unlocked with no nurse around. There were 2 CNA's observed working on the hallway where the medication cart was observed.On [DATE] at 12:33 AM, V25 (RN) stated she usually doesn't leave the medication cart unlocked when she isn't around it but sometimes, she forgets to lock it.On [DATE] at 9:10 AM, V2 (Director of Nursing) stated medication and treatments carts should be locked when the nurse is not around the cart and there should not be any medications or creams sitting on top of the carts not locked up unless the nurse is with it. V2 stated you should not borrow medications or creams from other residents. V2

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow the approved menu by not providing the approved protein and not serving the correct portion sizes. This failure has the ability to affect all 73 residents residing at the facility. Findings include:The facility Fall/Winter 2025 menu documents on 12/1/25 breakfast: choice of cereal, biscuits and gravy, margarine, orange, apple, or cranberry juice, milk, coffee/tea. The menu documented lunch: country chicken breast, garlic mashed potatoes, California vegetable blend, cornbread, chef's choice of dessert, gravy, margarine, milk, coffee/tea. 1. R3's Face Sheet documents an admission date of 8/22/2018 with diagnose including in part Parkinson's disease, type 2 diabetes, long term use of insulin, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, and diaper dermatitis. R3's MDS dated [DATE] documents a BIMS of 15, indicating R3's cognition is intact. On 12/1/25 at 8:26 AM, R3 was in bed eating breakfast. Observed R3 was served scrambled eggs, hot cereal, toast, coffee, and water. R3 stated he hasn't had meat with his breakfast for a while and he likes having meat with his breakfast because he is supposed to have double protein, and the eggs aren't good and are usually cold. R3 stated they have eggs all pretty much every morning. R3 stated on his meal ticket he is supposed to get double protein and milk, and he doesn't get double protein very often and he hasn't had his milk in a long time because one of his special cups started leaking so they had to throw it away and they haven't replaced it. On 12/1/25 at 8:34 AM, R8 was served scrambled eggs, cereal, and toast. R8 who was alert and oriented stated they haven't had breakfast meat with their breakfast in a week or 2 and he likes having meat with his breakfast. On 12/1/25 at 8:34 AM, R9 was served scrambled eggs, cereal, and toast. R9 who was alert and oriented stated they haven't had meat with their breakfast in a week or 2 and she likes having meat with her breakfast. On 12/1/25 at 8:35 AM, R10 was served scrambled eggs, cereal, and toast. R10 who was alert and oriented stated they haven't had meat with their breakfast in a while and she likes having meat with her breakfast. On 12/1/25 at 8:41 AM, V10 (Certified Nursing Assistant/CNA) stated the residents were served scrambled eggs, hot cereal, and toast for breakfast this morning and no meat. On 11/26/25 at 9:39 AM, R2 who was alert and oriented stated they haven't served meat for breakfast for several days, then stated, I told you that the food is terrible. On 12/1/25 at 9:17 AM, V11 (Cook) stated she didn't make meat with breakfast because they do not have any. V11 stated they haven't had meat for breakfast for about a week. V11 stated they did not have what was on the menu for breakfast because she made biscuits and gravy over the weekend, so she didn't have the ingredients to make them today, so she made scrambled eggs, cereal, and toast for today. V11 stated she decided on the menu for today, and did not consult the dietitian. V11 stated she didn't give R3 milk today because he only has 2 cups, so she gave water and coffee. V11 stated R3 needs a 3rd cup ordered and she doesn't know who orders the cups. V11 stated she worked at the facility a while back and R3 had 3 cups at that time but since she's been back this time (about 2-3 months) he has only had 2 cups. V11 stated they are supposed to have chicken for lunch today, but they do not have any, so she decided to serve Salisbury steak, mashed potatoes, and green beans. On 12/1/25 at 9:29 AM, V4 (Dietary Manager) stated they won't get their next food truck until Thursday of this week. V4 stated she was not aware they were out of breakfast meat. V4 stated they are out of chicken for lunch today as well so V1 subbed Salisbury steak. V4 stated she ordered for 2 weeks on her last truck instead of 1 week due to the Thanksgiving holiday falling on the day they normally get their food truck, but she must have not ordered enough. On 12/1/25 at 3:06 PM, V28 (Cook) stated they didn't have any breakfast meats this past week for breakfast. V28 stated he did let V4 (Dietary Manager) know that we were out of breakfast meat. V28 stated he thinks the reason they ran out of the breakfast meat was because of the holiday and V4 had to double order back to back. On 12/2/25 at 3:18 PM, V19 (CNA) stated she saw there wasn't any meat served with breakfast for a couple of days, and she stated there were several residents that complained to her, R3 and R4 are the 2 she can remember off the top of her head. 2. The facility Fall/Winter 2025 menu documents on 12/3/25 dinner: smoked sausage, sauerkraut, sweet peas, fruit cocktail, milk, coffee/tea. On 12/3/25 at 4:50 PM, observed dinner meal on the rehab unit. Bite size hot dog/sausage pieces were served. Each resident was served 4 bite size pieces of hot dog/sausage. The hot dog/sausage was thin and small/thin in size. On 12/17/25 at 2:05 PM, V47 (Cook) stated he usually works for lunch and dinner service. V47 stated he has served cut up sausage and sauerkraut before. V47 stated they cook the sausage whole then cut them into bite size pieces. V47 stated when the sausage is cut up, they are cut up into about 9 or so pieces per

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Healthcare of Energy	210 East College Energy, IL 62933

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain food items served to residents at palatable/hot temperatures for 4 of 4 residents (R1, R2, R3, R14) reviewed for food preferences in the sample of 44. Findings include:On 11/26/25 at 7:00 AM, a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit. 1. R1's Face Sheet documents an admission date of 10/16/2023 with diagnoses including in part multiple sclerosis, unspecified protein-calorie malnutrition, non-pressure chronic ulcer of left heel and midfoot with unspecified severity, vitamin B12 deficiency anemia, nutritional anemia, and weakness. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 08, indicating moderate cognitive impairment. R1's Care Plan documents a problem category of nutritional status, documenting R1 is at risk for impaired nutrition and hydration. R1's Physician Order Report dated 11/2/25-12/2/25 documents R1 is on a regular diet with regular consistency and thin/regular liquids. On 11/26/25 at 8:00 AM there was a plate of untouched food sitting at the table in the dining room with no cover on it and no resident was near it. This surveyor asked V7 (Certified Nursing Assistant/CNA) whose food it was, and he stated it was R1's but she wasn't out of bed yet because he needed help to get her up and they hadn't had time yet. On 11/26/25 at 8:25 AM, V5 (Certified Nursing Assistant/CNA) put a cover on the food that was sitting at the table for R1, took the tray from the table and took it to R1's room to assist her with eating. V5 poured milk into her cold cereal then this surveyor asked V5 to see if she could get another tray for R1. V5 went to the kitchen and brought back a new tray for R1. The 1st tray was temped at 8:28 AM, the biscuits and gravy were 94.8 degrees Fahrenheit, the scrambled eggs were 93.6 degrees Fahrenheit, and the milk in the cold cereal was 61.3 degrees Fahrenheit. V5 stated she usually microwaves the food if she thinks it is cold. On 11/26/25 at 8:28 AM, R1 stated she gets cold food often. R1 was orientated to person, place, time, and situation during interview. 2. R2's Face Sheet documents an admission date of 12/23/24 with diagnoses including in part spina bifida, anemia, paraplegia, pressure ulcer of sacral region stage 4, and pressure ulcer of right buttock stage 4.R2's MDS dated [DATE] documents a BIMS of 15, indicating R2's cognition is intact.On 11/26/25 at 9:39AM, R2 stated the food is terrible, and it is always cold when he gets it. 3. R3's Face Sheet documents an admission date of 8/22/2018 with diagnose including in part Parkinson's disease, type 2 diabetes, long term use of insulin, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, and diaper dermatitis. R3's MDS dated [DATE] documents a BIMS of 15, indicating R3's cognition is intact. On 12/1/25 at 8:26 AM, R3 stated he hasn't had meat with his breakfast for a while and he likes having meat with his breakfast because the eggs aren't good and are usually cold. R3 stated today the eggs were cold so he couldn't eat them. 4. R14's Face Sheet documents an admission date of 8/22/2025 with diagnoses including in part malignant neoplasm of colon, depression, other symptoms and signs concerning food and fluid intake, nausea with vomiting, secondary malignant neoplasm of large intestine and rectum, and generalized anxiety disorder. R14's MDS dated [DATE] documents a BIMS of 14, indicating R14's cognition is intact. On 12/3/25 at 2:38 PM, R14 stated the food is cold all the time and breakfast is always cold. R14 stated lunch and dinner are cold some days and some days it is okay. On 11/26/25 at 3:03, V5 (CNA) stated she has received complaints from residents about cold food before and she will tell kitchen and warm the food up if they tell her before they eat it. On 12/1/25 at 3:27 PM, V10 (CNA) stated she has had residents complain about cold food and usually its breakfast food. On 12/2/25 at 2:26 PM, V20 (CNA) V20 stated she receives resident complaints a lot about their food being cold. On 12/03/25 at 2:19 PM, V21 (License Practical Nurse) stated the residents get served cold food daily. V21 stated she would take and heat it up or give them a new tray, but they often don't let her know that the food is cold until after they eat it. On 12/2/25 at 12:23 PM, V1 (Administrator) stated if food is cold, it should not be served to the resident, it should be reheated. V1 stated food should go from the steam table to the resident and not sit on the table if they are not in the dining room at the table ready to eat. The Facility's Cooking Foods- Internal Temperatures policy dated January 2012 documents, Temperature Guidelines: Food- Hot at Point of Service, 120 degrees or higher. Food- Cold at Point of Service, 50 degrees or lower.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to discard food items in the refrigerator and dry storage that were past the used by/expiration dates. This has the potential to affect all 73 residents living in the facility Findings include:On 11/25/25 at 12:10 PM, observations of the kitchen began. In the reach in freezer there was an unopened bag of crumbled sausage that had an expiration date of 11/9/25. On the storage rack there was an unopened container of strawberry glaze that had an expiration date of 10/25/25. On the storage rack there was an opened bottle of chocolate fudge that had 5/23 on it as the open date and had an expiration date of 11/13/25 on it. There were 2 unopened bags and 1 open bag of cookie pieces that had an expiration date of 11/23/25. There were 2 unopened boxes of cornstarch on the storage rack that had an expiration date of 8/28/23. There was a bag of opened tortilla chips on the storage rack that had an expiration date of 9/17/25 and no open date. V4 (Dietary Manager) was shown the expired food and stated they were no good anymore and she threw them all out. V4 stated expired food should never been kept, it should be thrown out. On 11/25/25 at 12:20 PM, observed refrigerator in kitchen and noted six cartons of eggs, five cartons had an expiration date of 11/17/25 and one had an expiration date of 11/14/25. On 11/25/25 at 12:40PM, V4 stated that she was going to throw away the eggs in the refrigerator that she said she brought the eggs a little while back and was going to cook out on the grill and make some hard fried eggs for some of the residents. She said that she never had a chance to make the eggs, and she was just going to get rid of them. On 11/25/25 at 1:05 PM, a container that had a sauce-like substance in it had a label that was marked Manwich with no date of when placed in the refrigerator or opened. Observed 2 large open containers in the refrigerator, one was coleslaw dressing and one was Italian dressing both dressings were half empty and did not have an open date on either one. A facility policy titled Dry Storage Areas dated January 2012 documents under Procedure: 9. Cans and dried goods will be dated with the date they were received and date they were opened. The facility Midnight Census Report dated 11/25/2025 documents 73 residents in the facility.

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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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failure to ensure that all licensed staff had a current license while working at the facility. This failure has the potential effect all 73 residents living at the facility. The findings include: On [DATE] at 9:45AM, V20 (Certified Nurse Assistant/CNA) stated that V21 (Licensed Practical Nurse/LPN) is not working at the facility anymore due to the fact that her LPN license was not active. V20 stated she had been working in the facility as and LPN while it was expired. On [DATE] at 10:06AM, V1 (Administrator/ADM) stated the BOM (Business Office Manager) or corporate checks staff nursing licenses. V1 stated V21's license expired at the beginning of the year but he thinks she might have gotten an extension on it but he isn't sure. V1 stated V21 did work as a nurse with an inactive license and passed medications and performed nursing duties during that time. V1 stated V21's LPN license became active again on [DATE]. On [DATE] at 11:30AM, V1 (ADM) said that he suspended V21 (LPN) on [DATE] because she didn't have an active nursing license. On [DATE] at 9:10AM, V2 (Director of Nursing/DON) stated she was not aware V21 did not have an active license. V2 said that typically corporate checks licenses at hire and then when it is renewal time. V2 stated she will have the nurses bring her proof that they renewed their license, but she doesn't keep that proof because she doesn't want to be responsible for that. V2 stated she doesn't remember if V21 provided anything or not. She stated this year things have gotten past her. V2 stated she doesn't know when V21's license expired or how long she worked without and expired license she just knows she did work some without an active license. V2 stated she heard about a CNA working without a certificate, but she doesn't remember who told her and she thinks V1 handled it. V2 stated corporate does the checks on the nurses' license prior to starting to work.On [DATE] at 9:32AM, V3 (Assistant Director of Nursing/ADON) stated she wasn't aware that V21 didn't have an active nursing license until after she was suspended. V3 stated V21 floated around when she worked so she could have worked on all the floors in the whole buildingOn [DATE] at 8:32AM observed V21 administering medications to R10 at the facility. On [DATE] at 8:45AM observed V21 administering medications to R28 at the facility.On [DATE] at 2:19PM observed V21 working on A hall and suites at the facility as an LPN.On [DATE] at 10:32AM observed V21 working C hall at the facility as an LPN. A document titled Licensed Practical Nurse Job description undated, documents Job summary as: The overall purpose of the Licensed Practical Nurse (LPN) position is to perform practical nursing work under the general supervision of a registered nurse. The LPN participates in the assurance of the provision of resident care services consistent with accepted standards of care and assigns duties to C.N.A's (Certified Nurse Assistant's) as appropriate. Essential Duties and Responsibilities: Performs duties and responsibilities with assigned functional area within a nursing home facility which may include, but are not limited to, any combination of the following task: Dedicated to delivering a high level of customer service, Consistent and regular attendance, provided resident care in accordance with accepted standards of practice and within the score of the LPN license, observes and reports on resident's conditions/changes and then documents in accordance with facility policies and as required by regulations, administer medication/treatment as prescribed within the LPN scope of practice, receives, transcribed and executes physician orders, implements and evaluates resident's plan of care, identifies and secures equipment and supplies. Notifies supervisor when supplies are needed, informs subordinate staff about the condition of residents and expectations/needs for the shift assigned at the beginning of each shift and receives report form subordinates throughout and at the end of each shift regarding resident's conditions, directs CNA's to assure care provided according to standards of practice and according to facility policies and regulations, rounds with CNA's prior to end of shift to assure unit is in proper order, communicates appropriate and thorough information to oncoming licensed staff so that continuity of care is provided from shift to shift, completes nursing documentation as indicated, i.e, admission paperwork, ongoing pain, documentation, etc., assures residents are as free from pain as possible and advocates for residents with physicians as needed, assures that resident's accident or incident is fully documented, investigated and reported in accordance with facility policies and per regulations, assures that each resident' attending physician and family/responsible party is promptly is notified of any significant changes in the resident's health condition, performs incidental housekeeping or maintenance tasks as may be required to maintain a clean, hazard-free environment for resident's, visitors, and staff, assists in the evaluation of subordinate staff and any necessary counsel /discipline in accordance with facility policies, ensure a safe

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement enhanced barrier precautions while providing wound care for 5 of 5 residents (R15, R3, R17, R19, and R1) observed for wound care in a sample of 44.The findings include:1. R15's Face Sheet documents an admission date of 3/17/25 with diagnoses including in part pain, type 2 diabetes, primary hypertension, and venous insufficiency.R15's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) of 13, indicating R15's cognition is intact.R15's Care Plan documents R15 was admitted with skin ulcer/lesion and is at risk for further skin impairment with a start date of 3/17/25 and R15 requires antibiotic therapy for wound infection with a start date of 3/18/25 with interventions including provide meds as ordered and use good infection control measure with resident.R15's Wound Evaluation and Management Summary Report dated 12/10/25 documents that R15 has the following wounds: diabetic wound of the right calf, diabetic wound to the left calf, and a stage 4 pressure ulcer of the right heel.R15's Physician's Order Report dated 11/15/25-12/15/15 did not document an order for Enhanced Barrier Precautions.On 12/8/25 at 11:14 PM, observed V25 (Registered Nurse/RN) perform wound treatments on R15. An enhanced barrier sign was observed on the wall next to R15's door. V25 pushed the wound treatment cart into R15's room then applied gloves and was observed not wearing a gown, removed the wound dressing to right heel, then cleansed the wound with normal saline wound wash. V25 changed gloves without performing hand hygiene. V25 applied the treatment to the right heel. V25 then removed the old dressing to right calf wound and cleaned wound with normal saline wound cleanser. V25 then changed gloves without preforming hand hygiene. V25 applied the treatment on right calf and applied calcium alginate over the cream mixture. V25 then wrapped with gauze. V25 removed the wound dressing to the left calf then cleansed the wound with normal saline wound cleanser. V25 changed gloves without preforming hand hygiene. There was some bleeding from R15's left calf wound so V25 dabbed it with some gauze. Without removing gloves V25 then opened a drawer on the treatment cart and pulled out the jar of silver sulfadiazine cream. V25 didn't have a spoon to get the silver sulfadiazine cream out with so she left the room to get one with her gloves on, walked down the hall to the medication cart and got a spoon from the medication cart then returned to the room with the same gloves on. V25 then opened all 4 drawers and went through the supplies in each drawer with her gloves on looking for collagen. V25 could not find collagen so she removed her gloves, did not perform hand hygiene, and went to another unit to find collagen. V25 then returned and applied gloves then applied the treatment to the wound on R15's left calf. V25 then threw away supplies and placed the jar of silver sulfadiazine cream in drawer then removed gloves. V25 then pushed the cart out of the room back to the nurse's station. V25 did not perform hand hygiene at any time after leaving R15's room. V25 immediately starting prepping wound supplies for the next resident.2. R3's Face Sheet documents an admission date of 8/22/2018 with diagnoses including in part Parkinson's disease, type 2 diabetes, long term use of insulin, non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, and diaper dermatitis.R3's MDS dated [DATE] documents a BIMS of 15, indicating R3's cognition is intact.R3's Wound Evaluation and Management Summary Report dated 12/10/25 documents that R3 has the following wound: Skin tear to the left, lateral, upper buttock.R3's Care Plan documents a problem category of impaired skin integrity related to wound healing with risk of inadequate fluid and nutritional intake as evidenced by delayed wound healing, poor oral intake, and signs of dehydration with a start date of 2/12/25.R3's Physician Order Report dated 11/2/25-12/2/25 documents an order to place on enhanced barrier precautions per guidelines with a start date of 4/1/24 and an end date of open ended.On 12/8/25 at 11:45 PM, observed wound treatment for R3, this was a continuous observation from the previous wound treatment. R3 had a droplet and contact precautions sign on his door. V25 did not perform hand hygiene between the last resident and R3. V26 (Certified Nursing Assistant) and V25 donned gloves and a mask and V25 stated R3 is on isolation for Rhino virus so you only need to wear gloves and a mask. V26 and V25 was observed not donning a gown prior to entering R3's room. V26 and V25 then entered R3's room and V25 pushed the treatment cart into the room. V26 rolled R3 and there was no dressing on the left upper buttocks wound. V25 cleansed the wound with normal saline wound cleanser then changed gloves without performing hand hygiene. V25 applied the silver sulfadiazine cream and collagen mixture to wound, applied calcium alginate over cream mixture, then placed a dry dressing over wound. V25 then removed gloves and pushed the treatment cart out of the room. V25 then performed hand hygiene with