

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2026
NAME OF PROVIDER OR SUPPLIER  Helia Healthcare of Energy		STREET ADDRESS, CITY, STATE, ZIP CODE  210 East College Energy, IL 62933	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0690  Level of Harm - Actual harm  Residents Affected - Few	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to provide appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 5 residents (R7) reviewed for urinary tract infections in a sample of 39. This failure resulted in R7 being admitted to the hospital for disorientation and acute cystitis without hematuria. Findings include: R7's admission Record documented an admission date of 07/07/2025 with diagnoses including vascular dementia, unspecified severity, with other behavioral disturbance, mixed incontinence, personal history of Transient Ischemic Attack (TIA), and cerebral infarction without residual deficits. R7's Minimum Data Set (MDS) dated [DATE], documented under section C (Cognitive Patterns) a BIMS (Brief Interview for Mental Status) score of 11, indicating R1 has moderate cognitive impairment. This same MDS documents under section H (Bladder and Bowel) that R7 has urinary continence with occasionally incontinence (less than 7 episodes of incontinence). R7's Care Plan documented a focus area of urinary tract infections dated 1/14/2025 with interventions that include to observe for signs and symptoms of a urinary tract infection and notify physician as indicated. R7's Progress Note documented by V20 (Registered Nurse/RN) dated 11/27/2025 at 5:43 AM documents order from V22 (Nurse Practitioner/NP) on secure messaging to straight cath and send urine for urinalysis and culture in response to a message sent by prior shift nurse stating resident is confused and hallucinating and incontinent. There was no documentation provided by the facility of urinalysis with culture results from 11/27/2025 or any follow up documentation to V22 (Nurse Practitioner/NP) on R7. On 1/28/2026 at 10:29 AM, V20 stated she did remember making a note in R7's chart in regards to a straight catheter for diagnosis that included confusion. V20 stated she does not recall obtaining the urine sample since it was around 5:45 AM in the morning, she would have reported that off to the day shift nurse. R7's Progress Note documented by V25 (RN) dated 12/14/2025 at 8:48 AM documented entered R7's room to find her passed out in dinner plate. Left resident sitting up on side of bed eating dinner. Resident was alert to baseline at this time. Came back to check on resident where she was found, pulse present at 35, resp (respirations) 14, O2 (oxygen saturation) 94%, bs (blood sugar)-160. Responsive to verbal stimuli but not focusing with eye movement. (Name of ambulance company) contacted and picked resident up taking to (name of local hospital) ED (Emergency Department) at this time. On call notified, as well as POA (Power of Attorney). NP notified secure messaging. All necessary paperwork was sent with EMS (Emergency Medical Services). R7's Progress Note by V25 (RN) dated 12/15/2025 at 12:34 PM documented spoke to nurse at local emergency room who stated resident was stable, family present at bedside, and resident would be admitted for urinary tract infection. R7's After Visit Summary from the local hospital documents R7 was admitted on [DATE] and was discharged on 12/17/25. Under Discharge Information for the Receiving Facility documents encounter diagnoses of disorientation-primary, acute cystitis without hematuria, and essential hypertension. On 01/29/2026 at 9:12 AM, V22 stated she does have</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  146045	Facility ID:  146045  If continuation sheet Page 1 of 2

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F 0690  Level of Harm - Actual harm  Residents Affected - Few	documentation of request with order given to obtain a urine sample by straight catheter for R7 in regard to confusion, hallucinations and incontinence through secured messaging on 11/27/2025. V22 stated looking at hospital records it does not appear there were any urinalysis results from 11/27/2025 completed. V22 stated that the nursing staff should follow physician orders and contacted her if the urine sample was not able to be obtained. On 01/29/2026 at 9:33 AM, V2 (Director of Nursing/DON) and V19 (Assistant DON) both stated their expectations are for nursing staff to follow physician orders. V2 and V19 stated, V22 should have been contacted if the urinalysis could not be obtained for further orders. On 01/29/2026 at 9:46 AM, V1 (Administrator) stated his expectation is that all nursing staff follow physician orders by policy and procedure. The facility policy titled Obtaining and Following Physician Orders (revised July 2017) documented under Policy: It is the policy of (company name) that physician orders will be obtained by licensed personnel and followed. If the licensed professional does not in his/her best judgement think that the order is not in the best interest of the resident, he/she has the obligation to further investigate prior to fulfilling the order. If those orders are not followed for any reason, the Physician and Director of Nursing will be promptly notified.		