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 04/10/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to adhere to the guidelines for conducting a Resident Assessment to ensure accurate documentation and plan of care follow up resulted for 1 (R1) of 4 residents reviewed for assessments in the sample of 10. Findings include: R1's admission Record documented an admission date of 6/6/23 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.R1's Minimum Data Set (MDS) Brief Interview dated 1/16/26 documented a Mental Status (BIMS) score of 3, showing R1 had severe cognitive impairment. This same document under Section K Swallowing Disorder had a check mark next to coughing or choking during meals or when swallowing medications.R1's (MDS) Brief Interview dated 2/12/26 documented a Mental Status (BIMS) score of 4, showing R1 had severe cognitive impairment. This same document under Section K Swallowing Disorder had a check mark next to coughing or choking during meals or when swallowing medications. R1's Minimum Data Set (MDS) Brief Interview dated 3/03/26 documented a Mental Status (BIMS) score of 3, showing R1 had severe cognitive impairment. This same document under Section K Swallowing Disorder had a check mark next to coughing or choking during meals or when swallowing medications. R1's Care Plan did not have any focus areas related to R1 choking or coughing during meals or with swallowing medications.R1 Electronic Health Record did not contain any screenings related to coughing or choking.R1's Final Reportable sent to IDPH (Illinois Department of Public Health) documents on 3/10/26, R1 experienced an episode of choking while eating during meal service. The Heimlich maneuver was conducted and R1 was transported to the hospital. The report documents R1 was on a regular diet with thin liquids.On 4/8/2026 at 11:09 AM, V10 (Remote MDS Coordinator) stated she does work remotely and had completed R1's MDS's dated 1/16/2026, 2/12/2026 and 3/3/2026. V10 stated, she completed Section K, signs and symptoms of swallowing disorder with documentation of coughing or choking during meals or when swallowing medications with a check mark. V10 stated she based this assessment on R1's plan of care (POC) responses documented in his electronic health record (EHR) by the CNA (Certified Nursing Assistant) staff. V10 stated, upon review of January 2026, R1 had documentation of coughing or choking during meals on 1/4/26, 1/5/26, 1/8-1/11/26, 1/14/26, and 1/16/2026. V10 stated, in the month of February 2026, R1 had documentation of coughing or choking during meals on 2/5/2026, 2/10/2026, and 2/11/2026. R1's Plan of Care (POC) Responses for ADL-Eating documented on 1/16/2026 at 2:43 PM by V11 (CNA), R1 coughed or choked during meals or when swallowing medications. On 1/14/2026 by V4 (CNA) at 9:39 AM R1 coughed or choked during meals or when swallowing medications. On 1/11/2026 at 2:08 PM R1 coughed or choked during meals or when swallowing medications. On 1/9/2026 at 8:35 AM by V4 (CNA) R1 coughed or choked during meals or when swallowing medications. On 2/11/2026 at 11:31 AM by V4 R1 coughed or choked during meals or when swallowing medications. On 2/10/2026 at 9:00 AM by V4 R1 coughed or choked during meals or when swallowing medications. On 2/5/2026 at 12:21 PM by V11 R1 coughed or choked during meals or when swallowing medications. The was not documented for March 2026 look back period. On (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146045	A. Building B. Wing	04/10/2026

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/8/2026 at 11:23 AM, V4 (CNA) stated he had documented under the POC response section for R1 in January and February of choking or coughing during meals or swallowing medications. V4 stated, R1 would make sounds of clearing his throat during meals and non-mealtimes but did not think there was an issue with him doing it. On 4/8/2026 at 11:41 AM, V11(CNA) stated over the last few months R1 did have some coughing at times when he would eat or drink and she documented this in his POC response areas. V11 stated, she thought R1 had some congestion, and the nursing staff would give him cough medicine. On 4/8/2026 at 3:07 PM, V10 further explained, she completed R1's assessment by reviewing R1's EHR that included the CNA's documentation of choking or coughing during mealtimes or medication administration, all progress notes, therapy notes, etc. V10 stated, there is no interview or observation from her for his assessments. V10 stated, she does not report any concerns documented in the MDS, except if it was not accepted. V10 stated, it is protocol for the CNA staff to report issues to the nurses. On 4/9/2026 at 12:47 PM, V14 (Assistant Director of Nursing/ADON) stated MDS assessments are completed by V10 (MDS), remotely. V14 stated, R1's MDS's have not had proper follow up on concerns documented and V10 did not report concerns to the nursing staff as required. On 4/9/2026 at 2:42 PM, V1 (Administrator) stated, it is his expectations that staff are to follow the assessments policy and procedures and communicate with staff as required. Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (effective October 1,2025) documented under Section K, Steps for Assessment: 1. Ask the resident if they have had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D. Observe the resident during meals or at other times when they are eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorder are exhibited. 2. Interview staff members on all shifts who work with the resident and ask if any of the four listed symptoms were evident during the 7-day look-back period. 3. Review the medical record, including nursing, physician, dietary, and speech language pathologist notes, and any available information on dental history or problems. Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption.