

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/23/2026
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 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 interview and record review, the facility failed to provide timely ADL (Activities of Daily Living) assistance to dependent residents for transfers for 1 (R1) of 3 residents reviewed for ADL assistance in the sample of 5. The findings include: R1's Resident Face Sheet dated 6/18/26 documents an admission date of 4/30/24 and included diagnoses of chronic obstructive pulmonary disease, difficulty in walking, weakness, chronic atrial fibrillation, absence of left leg below knee, type 2 diabetes, chronic kidney disease and cardiomyopathy. R1's most recent Care Plan documents a Problem area of R1 is at risk for falls with a problem start date of 5/8/24. A corresponding Approach listed for this problem area documents to transfer with the assist of 1 and gait belt. The approach start date lists 3/1/26, however the approach lists a created date of 6/18/26 by V2 (Director of Nursing). Other Approaches listed document to keep call light in reach at all times with an approach start date 1/14/26 and to provide toileting assistance as needed with a start date of 1/14/25. Another Problem area documents R1 has impaired physical mobility related to left leg below the knee amputation and weakness with a start date of 5/8/24. The Goal listed for this problem area documents R1 will improve current mobility status to be able transfer without (Mechanical) lift. An Approach listed documents to provide extensive assistance during bed mobility, dressing, showering, locomotion, set up for meals, and mechanical lift transfers with an approach start date of 1/14/25. R1's most recent Minimum Data Set (MDS) dated [DATE] documents R1 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. This MDS also documents R1 requires substantial to maximum assistance of staff to roll left and right, sitting to standing, from chair to bed transfer, and toilet transfer. R1's Point of Care History dated 6/22/26 for transfers documents R1 was dependent for 18 out of 22 transfers from 5/23/26 - 6/22/26. On 6/18/26 at 8:41 AM, R1 stated last Saturday, 6/13/26 about 2:00 PM, R1 was sitting just inside the doorway of his room with his call light on. R1 said he had an episode of bowel incontinence and needed to be changed. R1 stated there was one Certified Nurse Aide (CNA), who passed his room multiple times going into rooms that didn't have their light on. R1 could not recall the name of the CNA. R1 stated the CNA and V8 CNA finally came to his room at about 4:00 PM. R1 said the CNA's walked out of his room without helping him. R1 stated he sat there in bowel incontinence for another 4 hours until the next shift came on at about 6:00 PM and assisted him with toileting hygiene and getting laid down into bed as he wanted originally at 2:00 PM. On 6/18/26 at 12:47 PM, V9 (CNA) stated R1 had initially wanted to get out of bed for the day at approximately 11:00 AM, at which time she and V8 used a mechanical lift to transfer R1 from bed to his wheelchair. V9 stated R1 then went back down to his room after lunch at approximately 2:00 PM, put his call light on and asked her to put him to bed. V9 stated she explained to R1 there were other residents who had been up longer and needed to lie down first. V9 stated R1 never told her he had an episode of bowel incontinence. V9 stated R1 is currently a 2 person transfer with a mechanical lift, so it would have taken her and V8 to safely put R1 to bed. V9 said R1 became angry with her at the time but did not remember what exactly he said. V9 stated she left the room and went back to work assisting the other residents getting laid down. V9 stated she finally got back to R1's room at around 4:00 PM to lay him down as he'd (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 146045
		If continuation sheet Page 1 of 2

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested earlier. V9 stated R1 became angry and began to yell at her why she had not answered his call light and put him to bed sooner. V9 stated she explained to R1 again there were other people who needed to be laid down first. V9 stated she didn't tell R1 this, but there was also another resident who had an episode of bowel incontinence which took her a lot of time to get cleaned up which caused her to run later. V9 stated R1 then began to escalate in his anger and grabbed her by the arm which scared her. V9 stated at that time she removed herself from the situation and reported the incident to V2 (Director of Nurses/DON) who told her to write a statement about what happened. V9 stated V14 (CNA) took care of R1's needs the rest of the evening. V9 stated she knew R1 did not get laid down till about 6:00 PM. V9 stated she was not sure why it was another approximate two hours before R1 got laid down in bed from 4:00 PM-6:00 PM. V9 stated V2 told her she would get another two CNA's to lay R1 down. V9 stated she was also told by V2 not to go back into R1's room the rest of the evening. On 6/18/26 at 2:52 PM, V8 (CNA) stated she worked on Saturday, June 13th with V9. V8 stated she remembers getting R1 up initially for the day right before lunch which would have been between 11:00 AM-11:30 AM. V8 stated she remembered R1 had put his call light on sometime after lunch requesting to be laid down, but she didn't remember exactly what time. V8 stated she remembered V9 stopping by and explaining to R1 they had a few other residents that had been up longer than him and needed to be laid down first. V8 stated they laid the residents down who had been up longer than R1, and then when they got back to R1 at a little after 4PM, R1 started yelling at V9 about why she didn't lay him down sooner. V8 stated after the argument and R1 yelling, she and V9 did not return to R1's room. V8 stated yes, four hours was too long for a resident to have to wait after requesting to be laid down. On 6/18/26 at 1:15 PM, V6 (CNA) stated she remembered putting R1 to bed the evening of Saturday June 13th. V6 stated she remembered it being sometime between 6:00 PM - 7:00 PM when she laid R1 down. V6 stated she remembered R1 telling her he'd been up for at least a couple of hours, and he was angry about that. V6 stated she did not remember if R1 was incontinent of bowel or bladder at the time, but she does know it's more difficult for R1 to use his urinal when he's sitting up. V6 stated V7 (CNA) assisted her to put R1 to bed. V6 stated it currently takes two CNA's to assist R1 with transfers because he is a mechanical lift for transfer. On 6/18/26 at 2:19 PM, V7 (CNA) stated she worked the evening of Saturday, June 13th. V7 stated she remembered assisting V6 with placing R1 into bed. V7 stated they got R1 into bed about 6:30 PM. V7 stated while they were assisting R1 into bed he complained he hadn't been changed in a while. V7 stated she remembered R1 had been incontinent of bladder but could not remember if he had been incontinent of bowel as well. V7 stated R1 also mentioned he had been up in his wheelchair since noon. On 6/22/26 at 12:35 PM, V14 (CNA) stated she worked on Saturday, June 13th on day shift. V14 stated she was never told by V2, V8 or V9 to provide any type of care to R1 on that day. When questioned if V14 believed four hours was too long for a resident to have to wait to be laid down from the time of their request to getting laid down in bed, V14 stated yes, she believed that was too long. On 6/18/26 at 3:23 PM, V2 (DON) stated she worked Saturday, 6/13/26 from 6:00 AM-7:00 PM as a staff nurse. V2 stated she remembered V8 and V9 coming to her to report the incident that had occurred with R1 yelling at V8 and V9. V2 stated she told V8 and V9 to make sure they always have a 2nd person with them when they provide care to R1. V2 stated she did not remember telling V8 and V9 to not go into R1's room again or that she would have someone else to put him to bed. V2 stated she did direct V8 and V9 to retrieve other CNA's to assist R1 to bed since he was being argumentative with them. V2 stated she believes it was about 4:45 PM when V8 and V9 approached her. When this surveyor asked if the approximate time of 11:00 AM-6:00 PM was too long for a resident who had initially requested to be laid down at approximately 2:00 PM was too long to wait, V2 stated, I believe residents should be accommodated at their request if they are cooperative with staff providing care. When V2 was asked if 4 hours was too long to wait between the time of the request of R1 to lay down and the actual time R1 waited to get laid down, V2 stated yes, it was. The facility's Safe Patient Handling Program Policy dated 9/8/23 documents, All resident care will be provided in a safe, appropriate and timely manner in accordance with the individual resident's Care Plan.		