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	01/30/2026

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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 (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

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F 0690 Level of Harm - Actual harm Residents Affected - Few	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.

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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 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. Based on observation, record review, and interview, the facility failed to ensure a medication cart was kept locked when out of staffs visual control. This has the ability to affect all 74 residents living at the facility.The findings include:On 01/27/2026 at 12:00 PM, V23, Licensed Practical Nurse, was observed passing medications in the facility's Suites dining room. V23 took glucometer supplies from the cart, left the cart unlocked, and went down the hall and into a resident room, leaving the unlocked cart out of her visual control.On 1/30/26 at 9:08am, V2, Director of Nurses, stated the cart is to be locked when out of staff's visual control.The facility Medication Administration Policy dated 10/25/14 documented, 16. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.The facility Midnight Census Report A dated 1/27/26 documented a total of 74 residents living at the facility.

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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 ensure that dishes were effectively sanitized in the dish machine. This failure has the potential to affect all 74 residents residing in the facility. The Findings Include:On 1/26/26 at 9:15 AM during the initial tour of the kitchen the sanitizer level in the dish machine was checked with sanitizer strips by V7 (Dietary Manager) and no sanitizer was registering. V7 attempted to run 2 more cycles stating that sometimes after it sits all night the sanitizer tubing gets clogged. V7 stated that she would contact the maintenance department and see if they could get the dish machine to dispense sanitizing solution appropriately due to the sanitizer strip not registering any sanitizer in the machine. V7 then confirmed that they had washed some dishes this morning and that no one had recorded a sanitizer level on the dish machine sanitizer log that morning. V7 confirmed this indicated that the level had not been checked prior to starting the breakfast dishes. V7 stated that it should be checked prior to starting the breakfast, lunch and dinner dishes. The facility's Machine Ware Washing policy revised January 2012 documents: Dishes, glassware, cups, utensils, and other dishware are washed, rinsed, and sanitized after each use. The machine for ware washing will be checked prior to each meal period to ensure that it is functioning properly. 1 Check sanitizer concentration using appropriate test strips . Record the date, temperatures, water pressure, and sanitizer concentration and initial the entry on the Dish Machine Monitoring Form. 2 .Check the Dish Machine Monitoring Form to ensure that temperatures, sanitizer concentration, and water pressure meet standards and that they are recorded daily. The Long Term Care Facility Application For Medicare and Medicaid dated and signed 1/27/26, documents 74 residents reside in the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow the recipe for pureed spaghetti and failed to provide the correct amount of bread for the lunch meal for 5 of 5 residents (R9, R12, R30, R45, R52) reviewed for altered diets in the sample of 39. The Findings Include: R9's admission profile documents an admission date to the facility on [DATE]. This same document includes the following diagnosis: Malignant neoplasm of oropharynx, other sequelae of cerebral infarction and generalized anxiety disorder. R9's current month's physician order sheet document that R9 has a pureed diet as tolerated. R12's admission profile documents an admission date to the facility on [DATE] and includes the following diagnosis: Alzheimer's, Dementia, and Cerebellar stroke syndrome. R12's current month physician's order sheet documents that R12 has a puree diet with thin liquids. R30's admission profile documents an admission date to the facility on [DATE]. This same document includes the following diagnosis: other sequelae of cerebral infarction, dysphagia, and depressive disorders. R30's current month physician order sheet documents that R30 has a puree diet order with double portions and nectar thick liquids. R45's admission profile documents an admission date to the facility on 6/21/2024. The same document includes the following diagnosis: cerebral infarction. R45's current month physician order sheet documents that R45 has a pureed diet with nectar thickened liquids. R52's admission profile documents an admission date to the facility on [DATE]. This same document includes the following diagnosis: Alzheimers, Dementia, depression and anxiety. R52's current month physician order sheet documents that R52 has a puree diet with thin liquids. An undated listed provided by the facility documents R9, R12, R30, R45, and R52 all receive puree diets.The facility's menu for Fall/Winter 2025 dated 12/1/25 the for the day of Tuesday 1/27/26 documents lunch was spaghetti, vegetable blend, wheat bread, chef's choice of dessert, margarine, milk/coffee/tea. On 1/27/26 at 11:15 AM, V18 (Dietary) was pureeing the spaghetti for the lunch meal. V18 stated at this time he had 5 residents with a puree diet order and one of those residents was to receive double portions, so he would prepare for 6 servings. V18 at this time using tongs dished 6 servings of noodles into the food processor and then using a large ladle scooped 6 portions of sauce into the processor with the noodles. V7 (Dietary Manager) told V18 to remember to add bread in the food processor when pureeing the main meal selection. V18 at this time added two slices of bread to the processor with the meat and noodle mixture. Once the mixture was at the desired consistency after adding beef broth, V18 scooped the pureed spaghetti into the serving dishes. The recipe for spaghetti with turkey meat sauce pureed is as follows for week 1 Day 3 lunch with a report date of 10/14/25 documents: Portion size= #6 scoop.Spaghetti - serving size 1 cupLow Sodium Chicken base- serving size 2/3 tablespoonWater- serving size 3/4 cupFood Thickener- serving size 2/3 Tablespoon 1. Prepare regular as directed. Strain liquid from turkey and pasta in the regular prepared recipe.2. Add turkey and pasta to food processor and process until fine in consistency.3. Add goulash liquid to processor, and process until smooth. Combine base and hot water and gradually add hot broth to mixture while processing to a smooth homogenous consistency.4. Add food thickener and process briefly until mixed. Scrape down sides of processor with a rubber spatula and process for 30 seconds. 5. Spread the mixture evenly into a steam table pan coated with food release.6. Cover tightly and heat to 165 degrees Fahrenheit.7. Portion one #6 scoop pureed Spaghetti with Turkey meat Sauce per serving. On 1/29/26 at 2:00 PM, V7 confirmed that 2 slices of bread is not adequate in serving size for 6 servings as listed on the menu/recipe. V7 stated they were advised by the dietitian to add bread and thickener to the main meal for better consumption even though the recipe does not mention that. V7 went on to state that the pureed food consistency was measured out by scooping the food into the serving bowls, so not measuring out the noodles was acceptable in pureeing the main meal selection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain aseptic technique while performing wound care treatment for 2 (R3 & R10) of 8 residents reviewed for wound care treatment and infection control in a sample of 39.The findings include:1.R3's Resident Face Sheet documents an admit date to the facility on [DATE] with diagnoses including multiple sclerosis, non-pressure chronic ulcer of the left heel and midfoot with unspecified severity, neuromuscular dysfunction of bladder, unspecified, and unspecified-macrocytic anemia.R3's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, indicating R3 had moderate cognitive impairment. This same MDS under section GG, Self-Care and Mobility, documented R3 is dependent, which means helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort for a chair/bed-to chair transfer.R3's Care Plan documented a focus area 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. Arterial ulcer right medial foot, skin tear left bottom of foot, deep tissue injury right buttock, and ulcer to posterior left knee, wound to right knee with interventions that included providing treatment/dressing changes as ordered.R3's Physician Orders by V17 (Wound Physician) dated 11/13/2025 documented silver sulfadiazine cream (SSD), 1 % (percent), cleanse the wound behind the right knee with normal saline or wound cleanser, apply SSD, Collagen powder, Calcium alginate, and dry dressing once a day; 1/01/2026 documented Betadine (povidone-iodine) solution, 10 %, cleanse the wound to the right plantar foot with wound cleanser or normal saline, apply betadine twice a day; silver sulfadiazine cream, 1 %, Cleanse the wound behind the left knee with normal saline or wound cleanser apply SSD, Collagen powder, Calcium alginate, triamcinolone cream, and dry dressing once a day; silver sulfadiazine cream,1%, cleanse the wound behind the lower right buttock with normal saline or wound cleanser, apply SSD, Collagen powder, Calcium alginate, and dry dressing once a day; and triamcinolone acetonide cream, 0.1%, cleanse the wound to behind the left knee with normal saline or wound cleanser, apply SSD, triamcinolone, Collagen powder, Calcium alginate, and dry dressing once a day.On 01/28/2026 at 1:20 PM, V17 (Wound Physician) observed in room to complete wound care with dressing changes for R3. V1 (Administrator) observed donning gown and gloves after hand hygiene. V2 (Director of Nursing/DON) observed outside of R3's door with wound cart and supplies. V17 observed gowned and gloved while standing by R3's bedside. V17 reached over and picked up the television remote control from R3's bed with his gloved hands and placed it on the window seal. V17 did not doff gloves, perform hand hygiene, or don new gloves. V1 (Administrator) was at R3's bedside to assist V17 with wound assessment and dressing changes. V17 was observed measuring the right lateral foot wound, then cleaning the area as ordered. V17 did not doff gloves, perform hand hygiene, or don new gloves. V17 requested V1 to turn R3 on her left side. V1 assisted R3 on her left side for V17 to observe buttock area. Fecal matter was observed on R3's incontinent pad and in the crevice of her buttock. V17 then removed the old dressing from R3's right lower buttock area, dropped the dressing on R3's bed, and then measured the wound. V17 stated, to V2 (Director of Nursing) that a new area on the right upper buttock was noted with measurements given. V17 requested 2 dressings for R3's right buttock from V2. V17 doffed his gloves and donned new gloves that had been pulled from his right pants pocket. V17 did not perform hand hygiene prior to donning the gloves. V17 then put his bandage scissors in the front of his isolation gown by making a hole in the gown for them to be held there. At 1:26 PM, the bandage scissors fell from V17's isolation gown onto the floor of R3's room. V17 was observed picking up the scissors and walked them to V2 (DON) at the door. V17 did not doff gloves, perform hand hygiene, or don new gloves after picking the scissors up off the floor. V17 was then observed walking over to R3's bedside table and moved her soda can for V1 (Administrator) to place a barrier with open dressing supplies on table. Wearing the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	same gloves, V17 cleaned R3's right buttock and placed a dressing to the area. V17 doffed gloves at this time and he donned new gloves that he removed from his pant pockets, without performing hand hygiene. V17 cleaned R3's new area to her upper right buttock and placed a new dressing as ordered. At 1:31 PM, V17 removed an old dressing from R3's right knee and obtained measurements. V17 cleaned R3's knee then walked over to the door to request another dressing from V2 (DON) who was at the door. V17 did not doff gloves, perform hand hygiene, or don new gloves. V17 returned to R3's bedside to clean R3's knee and placed the dressing as ordered. V17 then doffed his gloves and donned new gloves from his pocket without performing hand hygiene. At 1:37 PM, V17 removed the dressing from R3's right foot, debrided the wound area with scabs falling from the area to R3's bed with no barrier. V17 then cleaned the site, placed a dressing then wrapped gauze around the site as ordered. V17 removed dressing from the left knee with measurements taken. V17 debrided this area with no barrier on R3's bed. V13 cleaned the site and applied new dressing with no doffing or donning of gloves or hand hygiene. V17 walked over and pushed R3's call light for staff to come complete incontinence care. There was no observation of V17 performing hand hygiene after the treatments were completed prior to V17 leaving the room. On 01/28/2026 at 3:15 PM, V10 (Regional Director) stated it is her expectation that fecal incontinence would be cleaned up prior to any wound treatment.On 01/29/2026 at 8:51 AM, V2 (DON) stated all staff and contracted employees should follow all facility policies and practices. V2 stated, it is her expectation that all staff and contracted employees adhere to standard infection control practices and that would include donning and doffing gloves appropriately, hand hygiene, and cleaning fecal incontinence prior to starting wound care. 2. R10's Resident Face Sheet documents an admission date of 8/22/2018 with diagnoses of Parkinson's disease without dyskinesia, Vitamin B deficiency, Hypertension, GERD without esophagitis, Urine Retention, Neuromuscular dysfunction, Type 2 Diabetes Mellitus, Long Term Insulin use, Hypothyroidism, Hyponatremia, Acute and Chronic Respiratory Failure, Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, History of Urinary Tract Infections. R10's MDS dated [DATE] documents a BIMS score of 15 indicating R10's cognition is intact. Section GG, Functional Abilities, documents R10's mobility is via of a wheelchair. R10 is dependent for oral hygiene, toileting, shower/bathing, dressing, personal hygiene, position changes and transfers. Section M, Skin Conditions, documents R10 is at risk for pressure ulcer/injuries. Treatment include pressure reducing device for chair and bed.On 01/28/2026 at 1:55PM, V1 (Administrator), V2 (Director of Nursing /DON), and V17 (Wound Physician), were wearing disposable gowns and gloves, began wound treatments/assessment of wounds on R10. R10 had a border gauze dressing noted to Left upper buttocks dated 1/28/2026. V17 removed dressing and measured wound. V17 then removed his gloves and walked outside the room to the treatment cart where V2 had prepared a dressing of calcium alginate, silvadene cream and collagen powder. V2 handed the dressing to V17 after V17 donned a pair of gloves and no hand hygiene was observed at this time. V17 then went and applied the dressing to the left upper buttocks and secured it with a border gauze. V17 began to measure other open areas as follows: left lower buttocks, right thigh, right upper buttocks, and scrotum. V17 then doffed his gloves and went outside the room and instructed V2 to get a dressing prepared of Calcium Alginate, silvadene, collagen powder and border gauze. V17 donned gloves that he removed from his pocket and without hand hygiene. V17 then took the dressing to R10's beside and applied the dressing to R10's left lower buttocks (open area). V17 then went back outside the room to V2 and had V2 to prepare another dressing of Calcium Alginate, Silvadene, Collagen powder and border dressing and V17 took the dressing to the bedside and applied to R10's right upper thigh (open areas). V17 then doffed gloves and stated, I guess you expect me to use hand sanitizer after I change my gloves. V17 then applied hand sanitizer to his hands and donned another pair of gloves that he retrieved from his pocket. V2 prepared another dressing of Calcium Alginate, Silvadene, Collagen powder and border gauze. V17 took the dressing into R10's room and applied it to R10's upper right buttocks (open area). V17 then instructed V1 to get silvadene and apply to the open area to R10's scrotum. V17 then (continued on next page)

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