STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146088	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Healthcare of Benton	1310 Mark Franklin Louis Street Benton, IL 62812

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 Note: The nursing home is disputing this citation.	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 ensure a resident who enters the facility with an indwelling catheter is assessed for removal of the catheter as soon as possible, and to provide appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 (R1) residents reviewed for catheters in the sample of 8. This failure resulted in R1 being hospitalized for a Urinary Tract Infection and altered mental status.Findings include:R1's Face sheet documents an admission date of 9/29/2025 from a local hospital and documents a discharge date of 12/4/25 with the following diagnoses in part; Displaced supracondylar fracture without intercondylar extension of lower end of left femur, subsequent encounter for closed fracture with routine healing, rash and other nonspecific skin eruption, periprosthetic fracture around internal prosthetic left knee joint, and urinary retention.R1's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 was severely cognitively impaired.R1's Care Plan documents in the section titled, Problem that R1 requires an indwelling urinary catheter R/T (related to) urinary retention with a start date of 9/30/25. R1's Care Plan further documents the following in this section under approach. Urology consult as indicated and report symptoms of UTI (Urinary Tract Infection) with an approach start date of 9/30/25.R1's Physician's Order Sheet documents an order with a start date of 9/30/25 and a discontinue date of 11/22/25 for Indwelling Catheter - Change Catheter and Drainage Bag PRN (as needed).R1's Patient Referral from the local hospital with a print date of 9/26/25 documents under Patient Lines/Drains/Airway Status that R1 had a catheter that was placed on 9/24/25. There is no documentation that R1 had a history of urinary retention prior to his admission on [DATE] in this document.R1's Hospital Discharge Summary from the local hospital with a creation date of 9/29/25 and print date of 2/20/2026, documents R1 had an ambulatory referral to Urology. Under Assessment and Plan it documents Urinary Retention: Patient had urinary retention after removing Foley catheter. Place Foley catheter. Urology service is not on-call, will we are [sic] Foley catheter upon discharge and visit urology clinic at outpatient. There is no documentation that R1 had a history of urinary retention prior to this hospitalization.R1's Physician Progress Note authored by V12 (Physician) dated 10/17/25 does not document R1 had an indwelling catheter or documentation regarding urinary retention.R1's Progress Note dated 10/15/2025 at 10:59AM documents spoke with wife about urologist, she reported that he had put in for sx (surgery) and has no urinary retention dx (Diagnosis), sent md (medical doctor) request to d/c (discontinue) fc (foley catheter).R1's Progress Note dated 10/15/2025 at 2:34PM documents per md, referral sent to urology, awaiting their call to schedule an appt.R1's Progress Note dated 10/20/2025 at 2:44PM documents sent md message through (name of messaging service) about who was his referral sent to for urology wife was wanting to know when his appt. was. we have still yet to receive a call about an appt.R1's Progress Note dated 10/21/2025 at (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 Note: The nursing home is disputing this citation.	1:55PM documents reached out to (local hospital) urology et (and) was referred to (local hospital), was reported that they will call back in approx. 2 wks (weeks) for f/u (follow up).R1's Progress Note dated 10/30/25 at 1:35PM documents This nurse called and spoke with (V14-Family Member) about concerns he has.This nurse explained that Urology appointment is on 11/17/25 at 10:30AM at (name of clinic), he asked about the resident catheter, that he says it hurts, explained that it was placed when resident was in hospital and we cannot remove it without a doctor order and he needs to be seen for follow up with urologist on that regard.R1's Progress Note dated 10/30/25 at 3:34pm documents T/C (telephone call) to Urologist to determine if resident appointment could be moved up per family request. They state they do not have anything sooner than what is scheduled. This nurse asked if they had a wait list he could be put on in case of a cancellation, and she states they do and she put his information in the computer and would contact facility if change.R1's Progress Note dated 10/30/25 at 8:40pm, documents Message sent to NP (V11 Nurse Practitioner) updating on family concerns about urinary pain, catheter is patent and intact, draining amber urine without difficulty. Resident does pull on the catheter tubing at times so may have gotten germs from hand onto the catheter. Has urology appointment set up. Informed him of family concerns and requested to do a UA (urinalysis).R1's Progress Note dated 10/31/2025 at 2:40pm documents T/C (telephone call) received from NP (V11 Nurse Practitioner) he was asking about resident catheter and was place in hospital and has follow up with urology. NP states that is fine, just wanted to make sure if he didn't need it to try and remove. NP states if family continues to question, explain hospital said to see urology and it cannot be removed until that time. Explained that family had been educated on this.There is no documentation in R1's Progress Notes or R1's Physician Order History that an order to obtain a urinalysis was received.R1's Progress Note dated 11/2/2025 at 3:11pm documents Res (Resident) c/o (complaint of) not being able to urinate. Did assess abd (abdomen) and distention felt. Urine has much sedimentation in it. Did replace f/c (foley catheter) with # 16 French and a 10cc bulb. Good urine return noted. Upon later evaluation -Res states he feels better and abd distention is gone.R1's Progress Note dated 11/20/25 at 4:22pm documents Called Urology office .spoke with (staff member), informed her that we have not yet received office notes or orders from res (resident) visit earlier this week, and provider agreed to remove foley and allow res (resident) to void on his own. She is going to re fax office notes and orders at this time. Res has been up for meals and is currently in room visiting with family .R1's Progress Note dated 11/21/25 at 5:33pm documents Per urology's request, catheter was removed today without complication. explained procedure to patient, ensured privacy, and performed hand hygiene. catheter balloon fully deflated and catheter withdrawn smoothly. Tip intact. patient tolerated procedure well with no signs of discomfort or bleeding. Perineal area cleansed and patient instructed to increase oral fluids and staff notified to encourage him as well. will continue to monitor urinary output and signs of urinary retention.R1's Progress Note dated 11/23/25 at 1:27pm documents 11/23/2025 [Recorded as Late Entry on 11/24/2025 10:30 PM] Res up in wc (wheelchair) with mech assist for transfers. Res alert, and able to make needs known. Res is tolerating Foley cath removal and has been able to urinate this shift on his own and without cath in place. Fluids encouraged and taken well, res will take fluids despite having thickened liquids. Res appears calmer and less agitated since catheter removal and cont (continue) to void yellow urine without distress. Will cont to monitor.R1's Progress Note dated 12/4/25 at 12:22 AM recorded as a late entry on 12/5/25 at 12:23am documents This nurse was called to residents room as resident had change in behavior. Per wife resident did not speak or feed self at dinner but allowed wife to feed them. Resident prompted to say name and resident slurred response. Able to make eye contact for a short period and then resident eyes would roll back. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Spastic movements (short jerky motions) of body. Wife present. Sent to ER (name of hospital) for eval via EMS (Emergency Medical Services).R1's History and Physical Report from the local hospital dated 12/5/25 under History of Present Illness documents He presented to ER 9Emergency Room) with complaints of altered mental status from a local rehab facility. Family notes he has been in the facility for the last 2 months after a hip fracture. He went to facility for rehab. Family notes that he has been slowly deteriorating over the last 2 weeks. Speech declining, unable to feed self. ER workup significant for urine positive for UTI (Urinary Tract Infection), WBC (White Blood Cell) normal at 9.6, sodium elevated 157, lactic acid 2.8. He was given IV (intravenous) hydration and IV Rocephin. admitted to the floor for continued monitoring and management. Under Assessment and Plan diagnoses of altered mental status, UTI, and hypernatremia are documented.On 2/18/26 at 10:22am, V14 (family member) stated R1's catheter was not changed for over 4 weeks. V14 stated he was told they had to have urologist order to take it out, R1 only had the catheter for surgery and had no prior urinary issues. V14 stated he questioned administration several times about whether R1 could be dehydrated or have a UTI (Urinary Tract Infection). V14 stated he reported R1 was having urinary pain, and he was told they would request a Urinalysis but one was never done. V14 stated he requested to speak to the physician on more than one occasion but was never given the opportunity.On 2/18/26 at 2:11pm, V3 (Licensed Practical Nurse/LPN) stated R1's family was really concerned about him and his condition. V3 stated R1's family really tried to stay on top of his care. V3 stated she believes somewhere along the way the ball was dropped on scheduling R1's follow-up appointments. V3 stated R1 was admitted with a catheter and there was some confusion as to why it was still in place. V3 stated they called to get clarification, and it was left in place because R1 had some retention at the hospital, and they were waiting for R1 to follow up with urology for removal. V3 stated R1's catheter was really irritating for him; he would mess with it often. V3 stated R1's family did complain of it hurting him, but not to her. V3 stated if someone has a urinary retention and sediment with a catheter which resulted in it having to be changed, she would report symptoms to the physician. V3 stated even if symptoms were alleviated with catheter change. On 2/19/26 at 12:04pm, V4 (Licensed Practical Nurse/LPN) stated R1 did have a catheter that was put in at the hospital for surgery, but it was left in because he had urinary retention after surgery. V4 stated R1 had a referral for urology, and they were awaiting on that appointment to remove it. V4 stated R1 messed with it constantly, she was not sure if it was bothering him or if it was his anxiety. V4 stated she did change R1's catheter on or around November 2nd due to having retention and sediment in his drainage bag. V4 stated the new catheter was draining properly. V4 stated R1 had a standing order to change the catheter, so she did not have to contact the physician to let him know the symptoms that led to it being changed or that she changed it.On 2/23/26 at 1:35pm, V2 (Assistant Administrator) stated she covers the duties of Social Services Director when the facility does not have one. V2 stated if she was not provided with discharge instructions and follow-up appointments, she would reach out to the facility or hospital the resident came from and find out and make the appointments immediately. V2 stated she may not do it that day depending on when they admitted , but the next business day that she could. V2 confirmed that R1's urology appointment was not addressed until 10/15/25 and should have been addressed sooner.On 2/23/26 at 3:20pm, V1(Administrator) stated that she would expect a physician to be notified if a resident had urinary retention and abdominal distention, even if they had a standing order and symptoms were alleviated with catheterization.On 2/24/26 at 10:32am, V12 (Physician) stated he did R1's initial comprehensive evaluation in the facility. V12 stated R1's care was transferred to another provider shortly after. V12 stated there could be a few reasons why R1's catheter was not included in his initial (continued on next page)

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