STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048587	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA SOUTHBELT HEALTHCARE	101 SOUTH BELT WEST , BELLEVILLE, Illinois, 62220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2547413/2584414	S0000		08/26/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective	S9999		08/26/2025

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

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S9999	Continued from page 1 resident care plan. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Requirements were not met as evidenced by: Based on observation, record review, and interview, the facility failed to prevent resident to resident abuse for 1 of 6 residents (R3) reviewed for abuse in the sample of 8. This failure resulted in R3 having lacerations and bruising. Findings Include: On 8/13/25 at 1:00 PM, R3 was observed ambulating independently on the hallway he resides. R3 was wandering on the hallway, stopping at various doors but did not enter. R3 was alert to self only. R3's Face Sheet, undated, documents R3 has the following diagnoses: Dementia, Restless and Agitation, Unspecified Psychosis, Major Depressive Disorder, Generalized Anxiety Disorder, and Insomnia. R3's Minimum Data Set, MDS, dated 7/7/25, documents R3 has a BIMS (Brief Interview of Mental Status) score of 2, indicating R3 has severe cognitive impairment. R3's Care Plan, with a review date of 7/22/25, documents R2 is exhibiting wandering behaviors and is at risk for injury related to impaired safety awareness. He invades other's spaces without intention, gets confused where his room is. Interventions include: approach resident in a calm manner and to calmly que and redirect. R3's Progress Note, dated 4/4/2025 at 2:17 AM, documents the following: "Resident very confused. Wants to go back home, goes in others' rooms, got into verbal fight with (previous resident) in room 302 because (R3) kept going into the (previous resident's) room. Got into room 307, refused to get out of the female resident's room. Hit CNA (Certified Nursing Assistant), kicked me, the nurse. Together 3 CNAs got him into his room. Will keep monitoring." R3's Progress Note, dated 4/4/2025 at 5:13 AM, documents the following: "Slept for 90 minutes, still going into other rooms, up and down, monitored	S9999		

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S9999	Continued from page 2 behavior." R3's Progress Note, dated 4/7/2025 at 2:39 AM, documents the following: CNA informed this nurse (R3) wandered in another resident room and was attacked by resident. This nurse went in to check on (R3) and he was lying in bed, c/o (complaining of) back and neck pain. This nurse observed bruising and lacerations on his upper back and showers (shoulders). Resident AOx1 (Alert and Oriented to Self) and not able to describe what happened. Resident sent to (local hospital) for evaluation. Bed hold policy and all appropriate documents sent with resident. POA (Power of Attorney) called and informed of incident. MD (Medical Doctor) made aware." R3's Hospital AVS (After Visit Summary), dated 4/7/25, documents R3 was seen in the emergency room due to being an assault victim. R3's Abuse Investigation Final Report, dated 4/7/25, documents the following: A resident-to-resident altercation was reported to the Administrator that took place to between residents R3 and R8 (Former Resident). It was reported that R8 "stormed" R3 due to him trying to get into his (R8's) room. R8 was seen hitting, kicking, and scratching, R3 with scissors. The residents were immediately separated. R3 was assessed and was found to have scratches and was sent to the local emergency room for further assessment and treatment. He returned the same day with NNO's (no new orders). The scissors were taken from R8, and he was sent to the local hospital for a psychiatric evaluation. Upon his admission to the hospital, he was given an emergency discharge from the facility. R8's state guardian was notified of the decision. The facility MD (medical doctor), POA's, and local police were notified." R3's Psychiatry Initial Evaluation Note, dated 4/17/2025 at 12:09 PM, documents the following: "Chief Complaint: Initial Assessment. History of Present Illness: 71 y/o (Year Old) Male with Dementia and Agitation. History obtained from patient and staff. Patient pleasant and cooperative with assessment with intermittent confusion. Patient was recently involved in an altercation due to his wandering behaviors, where he was assaulted by another elderly dementia patient for wandering into his room. Patient was not seriously injured, treated and readmitted after being sent to the hospital. Patient can be difficult to redirect, and staff report he can then become easily agitated. Pleasant at time of assessment with some confusion and	S9999		

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S9999	Continued from page 3 nonsensical talk. Patient diagnosed with Alzheimer's Disease, psychosis, dementia, GAD (Generalized Anxiety Disorder), MDD (Major Depressive R3's Progress Note dated, 7/17/2025 at 9:40 AM, documents the following: "The Identified Offender was assessed using the Identified Offender Risk Assessment and scored a 9, indicating a compromised risk level. The resident continually exhibits significant cognitive impairment and consistent disorientation related to a diagnosis of dementia. The resident has a documented history of behavioral disturbances, including verbal aggression and sexually inappropriate behavior directed toward staff and other residents. The resident also has been known to frequently display wandering and rummaging behaviors. It has been highly recommended that ongoing monitoring and implementation of appropriate interventions should be continued to maintain the safety and well-being of all individuals within the facility." On 8/13/25 at 9:25 AM, V1, Administrator, stated he was not employed by the facility when the altercation between R3 and R8 took place. On 8/13/25 at 9:52 AM, V10, R3's Physician, stated he does not recall the incident between R3 and R8. The Abuse Prevention Policy, dated 9/29/22, documents the following: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain or mental anguish. As part of the resident social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of abuse for these residents. (B)	S9999		