STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0046672**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF ENERGY	**210 EAST COLLEGE PO BOX 519, ENERGY, Illinois, 62933**

(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 2558354/2604422	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210 d)1) 300.1610a)1) 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		

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

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S9999	Continued from page 1 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1630 Administration of Medication c) Medications prescribed for one resident shall not be administered to another resident. These regulations were not met as evidenced by: Based on interviews and record review the facility failed to ensure residents are free from significant medication errors for 1 of 3 residents (R1) reviewed for medication errors in sample of 13. This failure resulted in R1 receiving another resident's medication and being hospitalized for hypoglycemia. Findings Include: R1's Face Sheet shows documents an admission date of 10/16/2023 and includes diagnoses of Type 2 diabetes mellitus without complications, Alzheimer's Disease, Iron Deficiency, Cholecystitis, Renal Insufficiency, and Diaphragmatic Hernia without Obstruction. R1's Minimum Data Set (MDS) dated 8/6/2025 documents in section C, Cognitive Patterns, documents a Brief Interview for Mental Status (BIMS) score of 5, indicating R1 has severe cognition impairment. R1's "Progress Note" dated 8/30/2025 at 8:46AM, documents "Asked patient (R1) her name she said it was other residents name gave her that residents meds. BG (blood glucose) was 44 so gave orange juice with sugar to raise BG to 77. Notified ADN (V3 Assistant Director of Nursing), called ambulance, notified provider (name of provider)." R1's "Progress Note" dated 8/30/25 at 10:35PM documents that the local hospital was contacted for an update and R1 was admitted for Hypoglycemia.	S9999		

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S9999	Continued from page 2 On 9/5/2025 at 3:16PM, V9 (Licensed Practical Nurse/LPN) stated she was the nurse that accidentally gave R1 the wrong medications. V9 said prior to administering the wrong medications to R1, she saw R1 while R1 was in R1's room lying in bed. V9 stated when she checked R1's blood sugar, R1's blood sugar was 44. V9 said she provided R1 with some orange juice. V9 said after R1 drank the orange juice V9 rechecked R1's blood glucose and it had come up to 77. V9 said later in V9's shift (during morning medication pass) R1 was sitting in the dining room and when V9 asked R1 her name, R1 gave V9 the wrong name and gave the medications of the name (the name of R6) R1 gave her. V9 stated after she gave R1 the medications, a CNA stated, that is R1 not R6. V9 stated that is when she knew she made a medication error. V9 stated she could not remember what the medications were that she administered to R1 but they were R6's morning meds. V9 said when she realized the medication error had occurred, she reported this to V2 (Director of Nursing/DON) and then she sent the resident to the Emergency Room. V9 stated she does not work very often because she is in school, so she is not real familiar with some of the residents. V9 stated she also had called the physician and the Power of Attorney about the incident. V9 stated she had not administered R1's medications that were prescribed for that morning ordered for 7:00 AM to 10:00 AM after realizing her error. V9 stated she just received education from V2 on the date the medication error occurred (8/30/2025), on Medication Administration. R6's Medication Administration Record shows the AM (7:00AM-10:00AM) medications ordered for R6 that was given to R1 were Colace 100mg capsule, Ferrous Sulfate 325mg tablet, Furosemide 20mg tablet, Gabapentin 100mg capsule, Januvia 100mg tablet, Levothyroxine 125 mcg tablet, Lisinopril 20mg tablet, Magnesium Oxide 400mg tablet, Metformin 500mg tablet plus 250 mg tablet to equal 750 mg total, and Vitamin D3 50mcg capsule. R1's Physician Order Sheet documents an order for Lantus Solostar Insulin of 15 units subcutaneous once a day with an order date of 10/16/2023 and an order for BS checks dated 10/16/2023 for three times a day 7AM-10AM, 11AM-1PM, and 3PM- 6PM with sliding scale Regular Insulin per results. R1's Medication Administration Record dated 8/1/2025-8/31/2025 at 4:00AM-6:00AM documents R1 received Lantus Solostar Insulin 15 units subcutaneous and documents that it was administered by V19 (Registered Nurse). On 8/30/2025 at 7:00AM-10:00AM R1's blood sugar is documented as "Low."	S9999		

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S9999	Continued from page 3 On 9/5/2025 at 11:05AM, V2 stated she was made aware of the medication error and R1 was sent to the Emergency Room and was Admitted for Hypoglycemia. V2 stated an investigation was initiated. V2 stated that V9 was educated on Medication Administration. R1's Event Summary Report dated 8/30/2025 at 8:42AM documents the "medication error" under event details and the type of error as "incorrect medication." This report documents under "Interventions that V2 (Assistant Director of Nursing) was notified and R1's blood glucose level dropped to 44 and R1 was given orange juice with sugar raising R1 blood glucose to 77 after 20 minutes. Report shows Physician was notified on 8/30/2025 at 9:00AM, Family was notified at 9:00AM, and Care Plan was reviewed at 9:00AM. Evaluation: Sent to Emergency Room for evaluation and treatment. On 9/5/2025 at 7:15AM, V17 (Emergency Medical Technician/EMT) stated he has gone to the facility twice to pick up R1. V17 said one time was to transport R1 to the hospital due to R1 receiving the wrong medications that were actually for another resident. V17 stated the medications that were accidently given to R1 was documented on the run report. R1's (Emergency Medical Service) Report from the local EMS agency dated 8/30/2025 documents a chief medical complaint of "Accidental Medication Administration Multiple" and a secondary complaint of "hypoglycemia." The report documents "On arrival to scene, crew received a brief verbal report from the patients nurse. Nurse reported the following; medications were administered at approx. 08:05 today, 20mg Furosemide (diuretic), Aspirin 81mg, Colace 100mg, Ferrow [SIC] Sulfate 325mg, Gabapentin 100mg, Januvia 100mg (antidiabetic), Metformin 750mg (antidiabetic), Fish oil & Vit (vitamin) D3. They noted patient appeared lethargic and more confused to baseline, noted BGL (blood glucose level) 40s, administered oral glucose/glucagon prior to EMS arrival. Patient is baseline confused due to Alzheimer's. Discharged from (name of local hospital) last week for infection of wound site on antibiotics." R1's records from the local hospital document an admission date of 8/30/25 and a discharge date of 8/31/25. R1's Hospital Discharge Summary under Details of Hospital Stay documents "(R1) is a 96-year-old woman with diabetes who lives in a group home. She was inadvertently given another resident's medications, including diabetes medications. She became hypoglycemic and was brought to the emergency room. She was given	S9999		

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S9999	Continued from page 4 intravenous dextrose, oral nutrition and monitored with frequent AccuCheks. Her blood sugars normalized, and then she was discharged back to her nursing facility where she will resume her own previous medications." The facility policy titled "Medication Administration" (undated) documents under Procedures, Five Rights- Right resident, right drug, right dose, right route, and right time are applied to each medication being administered. A triple check of these 5 rights is recommended in the process of preparation of a medication for administration: 1) when the medication is selected, 2) when the dose is removed from the container, and finally 3) just after the dose is prepared and the medication put away. On 9/5/2024 at 3:10PM attempted to call V18 (Physician) but did not receive a call back. A facility policy for Medication Errors was requested from V2 on 9/5/2025 at 11:05AM. V2 stated she would see if they had one, but she was not sure. There was no policy provide by the end of survey on 9/12/25. (A)	S9999		