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 09/25/2025

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 Annual Certification & Licensure Survey	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)4)A) 300.1220b)3) 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		

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

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S9999	Continued from page 1 resident care plan. 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: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. This Requirement was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for hand contracture management and treatment for 1 of 1 resident (R34) reviewed for quality of care in the sample of 57. This failure resulted in R34 experiencing severe pain, infection, and a wound on her left hand. Findings Include: R34's face sheet, print date of 9/23/25, documented R34 has diagnoses including atherosclerotic heart disease, hypothyroidism, type 2 diabetes mellitus, hyperlipidemia, major depressive disorder, anxiety disorder, intermittent asthma, and muscle weakness. R34's MDS (Minimum Data Set), dated 7/4/25, documented R34 is moderately cognitively impaired.	S9999		

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S9999	Continued from page 2 R34's care plan, undated, documented resident has contractures of the right hand with interventions of ensure proper positioning as tolerated in bed and chair, meds as ordered and observe effectiveness of meds, observe for pain or increased stiffness, and notify MD of changes, provide gentle ROM (range of motion) during daily care as tolerated, and turn and reposition as needed while in bed/chair. R34's progress note, dated 9/15/25 at 2:10 AM, documented resident requested to go to hospital r/t pain in her left hand, this nurse informed her the wound care doctor would be in, resident stated "I fired him, he's insane send me to the hospital please this pain is unbearable." This nurse informed MD. EMS (emergency medical services) currently here to transport resident to (local hospital). R34's local hospital after visit summary, dated 9/15/25, documented reason for visit: finger pain, diagnoses deformity of left hand, injury, finger, left, initial encounter. Instructions: keep fingers apart as much as possible so not injuring each other. R34's care plan was not updated to reflect any interventions to keep R34's fingers apart as much as possible to prevent further injuries. R34's wound evaluation and management summary, dated 9/15/25, documented chief complaint: patient has a wound on her left plantar hand. Etiology: infection. Dressing Treatment Plan: antifungal OTC (over the counter) apply once daily and as needed. Etiology: infection. Duration: more than 3 days. Estimated time to heal: 9-12 months. Wound size (L x W x D): 3.2 x 2.1 x 0.3 cm. Surface area: 6.72 cm. Exudate: Light serous. Dressing treatment plan: antifungal OTC (over the counter) once daily and as needed, silver sulfadiazine once daily and as needed, gauze sponge once daily and as needed. R34's wound evaluation and management summary, dated 9/23/25, documented wound of the left, plantar hand, full thickness. Etiology: infection. Wound size (L x W x D): 3.5 x 2.1 x 0.3 cm. Surface area: 7.35 cm. Exudate: moderate serous. On 9/22/25 at 12:30 PM R34 was observed lying in bed with her left hand tightly contracted. R34's left hand had a foul odor coming from it. R34 did not have any devices in her left hand to reduce pressure between her fingers and the palm of her hand. R34's right hand was not observed to be contracted as documented in R34's	S9999		

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S9999	Continued from page 3 care plan. On 09/24/2025 at 3:31 PM R34 stated her left hand hurts all the time and the pain in her hand has gotten worse since she went to the hospital on 9/15/25. A foul odor was noted coming from R34's left hand. On 9/24/25 at 10:45 AM V20 Care Plan Coordinator stated she thought R34's right hand is her contracted hand. V2 DON (Director of Nursing) was present and stated she would go and observe R34's hands to check for contractures. On 9/24/25 at 10:57 AM V2 DON stated she checked R34's hands and it is her left hand that is contracted. V2 stated R34's care plan documented R34's right hand is contracted, and it is R34's left hand that is contracted. On 9/24/25 at 11:00 AM V27 Regional Nurse stated she expects the facility care plan staff to identify the correct extremities with contractures and implement appropriate interventions for contracture care. Surveyor asked V27 if she expects the facility staff to implement contracture care plan interventions such as hand rolls/hand splints to reduce the risk of residents developing wounds and/or infection and V27 replied "yes." The facility's ROM (range of motion)/Contracture Care Policy and Procedure, dated 2011, documented all residents will be assessed on admission and quarterly, or more often as a change of condition warrants, for risk factors for development of contractures. A program will be developed based on the resident's unique risk factors and involving formalized therapy and/or restorative nursing, as applicable. The program will be reflected in the interdisciplinary care plan and will be systematically and consistently followed. Formalized therapy will work closely with nursing staff, as appropriate, communicating and planning for goals and approaches so the team can be consistent in providing the care and services for maintaining joint mobility and for contracture care. It continues, procedure: 1. The nurse will start the functional assessment of new residents by completing the physical function sections of the MDS. 2. When further assessment is triggered for contracture risk or contracture care, further assessment will be done utilizing the designated functional assessment/rehabilitation module to perform further evaluation. 3. A physician's order will be obtained for physical or occupational therapy to evaluate and treat if there is any indication that the resident could benefit by these services. It continues,	S9999		

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S9999	Continued from page 4 8. When a resident has a contracture or contractures already present, formalized therapy will evaluate and work with the nursing department in setting up goals and approaches for the plan of care that specifically addresses this individuals' unique needs. 9. When splints and other contracture devices are part of the plan, formalized therapy will instruct nursing staff as to their use and recommend a schedule for applying and removing the device. 10. Individual plans for preventative ROM (range of motion) and contracture care will be followed as planned seven days a week. (B)	S9999		