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 10/28/2025

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 25510235/2647647	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active	S9999		

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

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S9999	Continued from page 1 participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review the facility failed to transport a resident in the appropriate wheelchair to prevent an accident for 1 (R1) of 3 residents reviewed for accidents in a sample of 10. This failure resulted in R1 falling face first into the dining room floor resulting in a left nasal bone deformity and both ulnar and olecranon fracture of the left upper extremity. The findings include: R1's Face Sheet documented an admission date to the facility of 2/09/25 with diagnoses including cerebral palsy, weakness, anxiety, and type 2 diabetes mellitus with diabetic neuropathy. R1's MDS (Minimum Data Set) dated 9/23/25 documents in Section C that R1 has a BIMS (Brief Interview of Mental Status) score of 15 indicating R1 is cognitively intact. The same MDS section GG-Mobility documents that R1 needed substantial/maximal assistance (helper does more than half the effort-helper lifts or holds trunk or limbs and provides more than half the effort) and uses a manual wheelchair for mobility. R1's Care Plan documents that R1 is totally dependent on nursing for all aspects of care related to Cerebral Palsy with interventions including "Ensure proper body	S9999		

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S9999	Continued from page 2 alignment when in bed or chair" with a start date of 10/10/25. R1's Care Plan also documented an update on 10/18/2025 with a category of pain: resident is at risk for pain related to: fracture resulting from fall on 10/18/25. On 10/22/2025 at 12:12 PM, R1 stated she did fall out of a wheelchair in the dining room on 10/18/2025. R1 stated she had been in a different wheelchair then her usual wheelchair. R1 stated the wheelchair she had been transferred to on 10/18/2025 was a high back wheelchair and she uses a standard wheelchair with no high back. R1 stated V11 (Certified Nurse Assistant/CNA) was moving her from the dining room table when she fell forward into the floor hitting her face and left arm. On 10/23/2025 at 11:00 AM, R1 further explained that she does use footrests with her normal wheelchair and stated her legs were too short to reach the footrests on the high back wheelchair that she was in when she fell on 10/18/2025. On 10/22/2025 at 1:37 PM, V8 (CNA) stated that he did transfer R1 from her bed using a mechanical lift to a high back wheelchair on 10/18/2025. V8 stated at the time he thought it was her wheelchair, however he learned later that it was another resident's wheelchair. On 10/23/2025 at 6:20 AM, V4 (CNA) stated he had been in assisting R1 from the dining room table when she fell the evening of 10/18/2025. V4 stated he went to assist R1 by pulling her wheelchair back from the dining room table and he made it about a foot when R1 fell forward hitting her face on the floor. V4 stated R1 had been in a high back wheelchair with no footrest at the time of the incident, and this is not her regular wheelchair. On 10/24/2025 at 8:25 AM, V17 (Occupational Therapist/OT) stated with R1's decrease in core strength, maximum assistance with mobility and her body size, R1 would appropriately fit the standard mechanical wheelchair that comes up to the base of her neck with foot pedals. V17 stated with a high-back wheelchair, the high-back part of the chair would be pushing on the back of R1's head and forcing her forward out of the wheelchair. V17 stated R1 would not be able to support herself while leaning forward and unable to reposition on her own. On 10/24/2025 at 9:40 AM, V9 (Registered Nurse/RN) stated she did assess R1 after her fall event in the dining room on 10/18/2025. V9 stated R1 had been	S9999		

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S9999	Continued from page 3 sitting in a high back wheelchair when she had fallen face forward on the dining room floor. V9 stated R1 had been sitting in a high back wheelchair and is not appropriate for her, because the high back wheelchair sits to high up for her and R1 had no core muscle control and is unable to reposition or balance herself. R1's Occupational Therapy Evaluation dated 10/12/2025 documented under Reason for Therapy: Clinical Impressions/Reasons for skilled services, R1 presents with impairment in balance, fine motor coordination, gross motor coordination, mobility and strength… Under Initial Assessment/Current Level of Function, Other System/Condition Assessment, Balance: Patient sits unsupported x 30 seconds with feet flat on floor and no back support? No; Amount of assist needed to sit at edge of bed is Moderate Assistance; Time patient can sit unsupported is 5 seconds… R1's local Emergency Room notes by V19 (Emergency Physician) documented under ED (Emergency Department) Course on 10/18/2025 that R1 had imaging of facial bones showing evidence of left nasal bone deformity and both ulnar and olecranon fracture of the left upper extremity. R1's Serious Injury Incident Report final report received on 10/24/25 documents under Detailed Incident Summary "see attached." The attached document titled "Final Reportable to IDPH - Fall with Fracture" documents under Conclusion "based on the investigation, the facility concludes the fall was accidental and related to forward momentum during wheelchair movement." The facility policy titled "Falls Management" (revision date July 2017) documents "It is the policy of (name of facility) to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions." (B)	S9999		