

Illinois State Department of Health

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 01/30/2026	
NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF ENERGY				STREET ADDRESS, CITY, STATE, ZIP CODE 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 Annual Licensure Survey Complaint Investigation 2650603/2718020		S0000				
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2)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. 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				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on interview and record review the facility failed to provide appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 5 residents (R7) reviewed for urinary tract infections in a sample of 39. This failure resulted in R7 being admitted to the hospital for disorientation and acute cystitis without hematuria. Findings include: R7's Admission Record documented an admission date of 07/07/2025 with diagnoses including vascular dementia, unspecified severity, with other behavioral disturbance, mixed incontinence, personal history of Transient Ischemic Attack (TIA), and cerebral infarction without residual deficits. R7's Minimum Data Set (MDS) dated 1/12/2026, documented under section C (Cognitive Patterns) a BIMS (Brief Interview for Mental Status) score of 11, indicating R1 has moderate cognitive impairment. This same MDS documents under section H (Bladder and Bowel) that R7 has urinary continence with occasionally incontinence (less than 7 episodes of incontinence). R7's Care Plan documented a focus area of urinary tract infections dated 1/14/2025 with interventions that include to observe for signs and symptoms of a urinary tract infection and notify physician as indicated. R7's Progress Note documented by V20 (Registered Nurse/RN) dated 11/27/2025 at 5:43 AM documents order from V22 (Nurse Practitioner/NP) on secure messaging to "straight cath and send urine for urinalysis and culture" in response to a message sent by prior shift nurse stating resident is "confused and hallucinating and incontinent." There was no documentation provided by the facility of urinalysis with culture results from 11/27/2025 or any follow up documentation to V22 (Nurse Practitioner/NP) on R7.			S9999			

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S9999	Continued from page 2 On 1/28/2026 at 10:29 AM, V20 stated she did remember making a note in R7's chart in regards to a straight catheter for diagnosis that included confusion. V20 stated she does not recall obtaining the urine sample since it was around 5:45 AM in the morning, she would have reported that off to the day shift nurse. R7's Progress Note documented by V25 (RN) dated 12/14/2025 at 8:48 AM documented entered R7's room to find her passed out in dinner plate. Left resident sitting up on side of bed eating dinner. Resident was alert to baseline at this time. Came back to check on resident where she was found, pulse present at 35, resp (respirations) 14, O2 (oxygen saturation) 94%, bs (blood sugar)-160. Responsive to verbal stimuli but not focusing with eye movement. (Name of ambulance company) contacted and picked resident up taking to (name of local hospital) ED (Emergency Department) at this time. On call notified, as well as POA (Power of Attorney). NP notified secure messaging. All necessary paperwork was sent with EMS (Emergency Medical Services). R7's Progress Note by V25 (RN) dated 12/15/2025 at 12:34 PM documented spoke to nurse at local emergency room who stated resident was stable, family present at bedside, and resident would be admitted for urinary tract infection. R7's "After Visit Summary" from the local hospital documents R7 was admitted on 12/14/25 and was discharged on 12/17/25. Under "Discharge Information for the Receiving Facility" documents encounter diagnoses of disorientation-primary, acute cystitis without hematuria, and essential hypertension. On 01/29/2026 at 9:12 AM, V22 stated she does have documentation of request with order given to obtain a urine sample by straight catheter for R7 in regard to confusion, hallucinations and incontinence through secured messaging on 11/27/2025. V22 stated looking at hospital records it does not appear there were any urinalysis results from 11/27/2025 completed. V22 stated that the nursing staff should follow physician orders and contacted her if the urine sample was not able to be obtained. On 01/29/2026 at 9:33 AM, V2 (Director of Nursing/DON) and V19 (Assistant DON) both stated their expectations are for nursing staff to follow physician orders. V2 and V19 stated, V22 should have been contacted if the urinalysis could not be obtained for further orders. On 01/29/2026 at 9:46 AM, V1 (Administrator) stated his		S9999				

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S9999	Continued from page 3 expectation is that all nursing staff follow physician orders by policy and procedure. The facility policy titled "Obtaining and Following Physician Orders" (revised July 2017) documented under "Policy: It is the policy of (company name) that physician orders will be obtained by licensed personnel and followed. If the licensed professional does not in his/her best judgement think that the order is not in the best interest of the resident, he/she has the obligation to further investigate prior to fulfilling the order. If those orders are not followed for any reason, the Physician and Director of Nursing will be promptly notified." (A)		S9999				