Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED B. WING IL6006704 07/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET** HELIA HEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) \$ 000 Initial Comments S 000 Complaint Investigation: 2345808/IL162030 S9999 **Final Observations** S9999 Statement of Licensure Violations: 300.610a) 300.1010a)1)2) 300.1010b) 300.1010c) 300.1010e) 300.1010h) 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 300.1010 Medical Care Policies a) Advisory Physician or Medical Advisory Committee 1) There shall be an advisory physician, or a medical advisory committee composed of physicians, who shall be responsible for advising the administrator on the overall medical Attachment A Statement of Licensure Violations management of the residents and the staff of the facility. If the facility employs a house physician, he may be the advisory physician. 2) Additional for Skilled Nursing Facilities.

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6006704 07/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET HELIA HEALTHCARE OF BELLEVILLE BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY S9999 Continued From page 1 S9999 There shall be a medical advisory committee composed of two (2) or more physicians who shall be responsible for advising the administrator on the overall medical management of the residents and the staff in the facility. If the facility employs a house physician, the house physician may be one member of this committee. b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided: arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee. c) Every resident shall be under the care of a physician. e) All resident shall be seen by their physician as often as necessary to assure adequate health care. h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health. safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident. injury or change in condition at the time of notification.

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PRINTED: 08/16/2023 **FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 1L6006704 07/24/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **40 NORTH 64TH STREET** HELIA HEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 2 S9999 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a physician has been designated to serve as the medical director of the facility. The facility also failed to ensure that the medical care of each resident is supervised by a physician. This failure affects all 40 residents residing in the facility. Findings include: A letter from V3, dated May 10, 2023, to the facility documents the following: Per the contract, I am providing you with a 30-day notice. Effective June 10, 2023, I will no longer function as the Medical Director, or attending for the facility. V3 submitted a statement to the Department dated 7/7/23, stating "as of 6/10/23 I, (V3), gave them, (the facility), an additional 28 days, as they stated, I, (V3), was required to provide each resident of their facility a written notice." ... "As of 06/24/23, I, (V3), notified them again that my team nor myself, (V3), will provide any care for their residents after 7/7/2023 and to find an attending MD." The Residents by Physician listing, dated 7/19/23, documents all 40 residents residing in the facility have V3 as their attending physician.

Illinois Department of Public Health

The Facility Matrix, CMS form 802, documents there are 14 residents on respiratory ventilators.

The Resident Census and Conditions of Residents, CMS (Centers for Medicare &

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diagnosis of Hypertension (HTN), Cerebral

R11's Face Sheet, undated, documents R11 has a diagnosis of Respiratory Failure, Pneumonia and ALS. V3 is listed as R11's physician. R11's Progress Notes, dated 7/19/23, document R11 was sent to the hospital with complaints of shortness of breath (SOB) and returned to the facility on 7/19/23. R11's Minimum Data Set (MDS), dated 5/11/23, documents R11 receives tracheotomy care and is on a respiratory ventilator. R11's After Visit Summary (AVS), dated 7/19/23, documents the following: diagnosed with SOB, increased tracheal secretions and tracheotomy complications; an order to schedule an appointment with V3 as soon as possible for a visit in 1 week.

R8's Face Sheet, undated, documents R8 has a

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The Physician Services policy, dated 12/2016, documents the following: The facility ensures that every resident will remain under the care of a

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