PRINTED: 09/25/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:					
		IL6003255	B. WING		08/13/2024			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HELIA SO	UTHBELT HEALTHCARE		H BELT WEST LE, IL 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) COMPLETE DATE					
S 000	Initial Comments		S 000					
	Annual Licensure and	d Certification						
S9999	999 Final Observations		S9999					
	Statement of Licensu	re Violations						
	1 of 2							
	300.615e)							
	Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information  e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)							
	This requirement was	not met as evidenced by:						
	perform criminal histo out of 4 (R25, R214, reviewed background the potential to affect facility.	ew the facility failed to ory background checks for 4 R215, R264) residents I screening. This failure has all residents residing in the						
	R25's Face Sheet, ur	ndated, documents R25 was						

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

(X6) DATE TITLE 09/03/24 **Electronically Signed** 

STATE FORM 6899 If continuation sheet 1 of 4 KQF611

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6003255	B. WING		08/1	08/13/2024		
HELIA SOUTHBELT HEALTHCARE 101 SOUTH			DDRESS, CITY, STATE  TH BELT WEST  LLE, IL 62220	DRESS, CITY, STATE, ZIP CODE  H BELT WEST				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE		
S9999	document they were a days after admission  R214's Face Sheet, uses admitted on 8/2/2 checks, document the 8/5/24, 3 days after a R215's Face Sheet, uses admitted on 7/30 checks, document the 8/5/24, 6 days after a R264's Face Sheet, uses admitted on 8/2/2 checks, document the 8/5/24, 3 days after a The Abuse Prevention 9/29/22, documents the 8/5/24, 3 days after a The Abuse Prevention 9/29/22, documents the shall check the crimin any resident seeking order to identify previe Prior to a new resider facility, this facility will name on the Illinois Sweb site. Check for the Illinois Department of search page. Conduct Background Check action of the Centers for Mediform 671, dated 8/6/2 residents residing in the CC)	R25's background checks, not completed until 8/5/24, 6 to the facility.  Indated, documents R214 24. R214's background by were not completed until dmission to the facility.  Indated, documents R215 Indated, documents R215 Indated, documents R264 Indated, documents R215 Indated, documents R216 Indated, documents R216 Indated, documents R216 Indated, documents R215 Indated, documents R216	\$9999	DEFICIENCY)				
	2 of 2							

Illinois Department of Public Health

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	COMPLETED	
		IL6003255	B. WING		08/13	08/13/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
HELIA SO		101 SOUTI	H BELT WEST				
HELIA SU	UTHBELT HEALTHCARE	BELLEVIL	LE, IL 62220				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5)  ( (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)		COMPLETE	
S9999	Continued From page	e 2	S9999				
	300.661						
	Section 300.661 Health Care Worker Background Check						
	A facility shall comply Worker Background ( Care worker Backgro	Check Act and the health					
	This requirement was	s not met as evidence by:					
	Based on interview and record review, the facility failed to obtain conduct pre-employment screening and obtain results of fingerprint checks to determine if employees had a prior criminal history which would disqualify them for employment. This had the potential to affect all the 104 residents living in the facility.						
	Findings include:						
	with a revision date of facility will not knowing convicted of resident misappropriation of p knowingly employ any of any of the crimes list. Worker Background of the provision of abuse listed on the III Registry. The facility any licensed staff that in effect against his of a state licensure body abuse, neglect, exploresidents, or misappropriation of the provision of the provi	roperty. The facility will not y direct care staff convicted sted in the Illinois Healthcare Check Act (unless waivered f The Act), or with findings of linois Health Care Worker will not knowingly employ at have a disciplinary action or her professional license by y, as a result of a finding of bitation, mistreatment of					
	· · · · · ·	s facility will: Obtain a copy					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
IL6003255		B. WING		08/13	08/13/2024		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HELIA SO	UTHBELT HEALTHCARE		H BELT WEST LE, IL 62220				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
\$9999	of the state license of for a position requiring. Check the Illinois Hea any individual being habuse previous finger sex offender website  On 8/9/2024 10 employment screed documented:  V29, Dietary staff was facility failed to ensure check was completed care to residents.  On 8/13/2024 at 9:45. Manager, BOM, state and background check employee starts. Their website that held thing. The Resident Census Residents, CMS 672,	any individual being hired g professional license. althcare Worker Registry on hired for prior to reports of aprint check results and the links on the registry."  Deep files were reviewed for the ening. The following was a hired on 8/1/2024. The ening a criminal background a prior to employee providing the ening and the ening and the ening are was a glitch with IDPH group."	\$9999				

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