STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146045	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HELIA HEALTHCARE OF ENERGY	**210 EAST COLLEGE, PO BOX 519 ENERGY, IL 62933**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0584 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on interview, observation and record review, the facility failed to ensure that resident equipment was maintained in good repair for 4 of 6 residents (R1, R6, R7, R8) reviewed for environment in the sample of 9. Findings include: On 08/26/2020 at 8:45 AM - 10:45 AM, R1, R7 and R8's wheelchairs had vinyl sections torn, causing the padding to be exposed and tattered. On 8/26/20 at 9:05 AM, R6 's wheelchair was worn with tears exposing the padding. At that time R6 stated she was aware her wheelchair was a little tattered. On 08/27/2020 at 8:45 AM, V3 (Maintenance Director) stated the facility had just discussed the repair of wheelchairs. The therapy department will let him know what parts to order or if the wheelchair is in need of too much repair, to order a new one and therap will provide the specifications of what to order. If the resident does not receive therapy, the CNAs or nursing staff will let him know either by work order or verbal acknowledgement. If it is just arm pads, he will repair them himself and if he has parts from other wheelchairs no longer in use, he will use those parts and repair the wheelchairs immediately.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.