IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

April 26, 2016

Nathaniel O. Brown
Weilmuenster & Keck PC
3201 West Main
Belleville, IL 62226

Re: Subpoena 16-027 / Anna L. Wolf v. Helia Southbelt Healtcare LLC dba Four Fountains (Case # 13-L-110)

Dear Requestor:

This letter is in response to your subpoena for records involving the Departments investigative files involving **incident number 42609**. Pursuant to federal regulations, 45 C.F.R. Part 2, "Testimony by Employees and the Production of Documents in Proceedings Where the United States Is not a Party," the Department, as a delegate state agency, is generally prohibited from complying with those requests that ask for federal certification surveys and corresponding surveyor testimony. Medicare surveys and findings are federal property belonging to the Department of Health and Human Services (DHHS) even though they are performed by a state agency. Please note that a subpoena served upon a delegate state agency shall be deemed a request under the Freedom of Information Act (FOIA), 5.U.S.C. 552.

Please find enclosed directly releasable documents in our possession and control. The rest of the Department's investigative file will be forwarded to the Center for Medicare and Medicaid Services (CMS), Region V, for disposition of the records as FOIA request. I have also included a form for your convenience to submit with a copy of your Subpoena to the below contact.

Edmond Agnissey
U.S. Department of Health & Human Services
CMS Regional Office
233 North Michigan Ave., Suite 600
Chicago, IL 60601

Should you have any further questions, please contact me at (217) 782-2043.

Sincerely,

Melissa Cheffy

Melissa Cheffy
Paralegal
Illinois Department of Public Health

Department of Health and Human Services
Medicare/Medicaid/CLIA Complaint Form

114120, 114124, 114125

Control Number: VE3F11 (IL00053203 IL00053207 IL00053209)

Part I - To Be Completed by Component First Receiving Complaint (SA or RO)

1. Medicare/Medicaid Identification Number
1 4 5 2 4 1

Facility Name and Address
HELIA SOUTHBELT HEALTHCARE
101 SOUTH BELT WEST
BELLEVILLE, IL 62220

3. Date Complaint Received
0 5 2 6 1 1
M M D D Y Y

4. Receiving Component
1 State Survey Agy.
[1] 2 RO

5. Date Acknowledged
0 5 2 6 1 1
M M DD Y Y

6A. Source of Complaint
1 [1]
2 [ ]
3 [ ]
1 Resident/Patient Family
2 Ombudsman
3 Facility Employee/Ex-Employ
4 Anonymous
5 Other

6B. Total Number of Complainants
0 3

7. Allegations

	7.A. Category	7.B. Findings (To be completed following investigation)	7.C. Number of Complainants per Allegation
1	1 8	0 1	0 3
2			
3			
4			
5			

7.A. Category:
1 Resident Abuse
2 Resident Neglect
3 Resident Rights
4 Patient Dumping
5 Environment
6 Care or Services
7 Dietary
8 Misuse of Funds/ Property
9 Certification/Un-authorized Testing
10 Proficiency Test
11 Falsification of Records / Reports
12 Unqualified Personnel
13 Quality Control
14 Specimen Handling
15 Diagnostic Erroneous Test Results
16 Fraud/False Billing
17 Fatality/Transfusion Fatality
18 Other (Specify) Accidents
19 Life Safety Code
20 State Monitoring

7.B. Findings (To be completed following investigation):
01 Substantiated
02 Unsubstantiated/ Unable to Verify

8. Action (if multiple actions, indicate earliest action)
[2]
1 Investigate within 2 working days
2 Investigate within 10 working days
3 Investigate within 45 working days
4 Investigate during next onsite
5 Referral (Specify)
6 Other Action (Specify)
7 None

ENTERED
JUL 06 2011
ENTERED

Part II - To Be Completed By Component Investigating Complaint (SA or RO)

9. Investigated by
[1]
1 State Survey Agency
2 RO
3 Other (Specify) _____

10. Complaint Survey Date
0 6 0 2 1 1
M M DD Y Y

11. Findings (Under 7B Above)
no deficiencies

12. Proposed Actions Taken by SA or RO
1: 2 1
2:
3:

1 Recommend Termination (23-day)
2 Recommend Termination (90-day)
3 Recommend Intermediate Sanction
4 POC (No Sanction)
5 Fine
6 Denial of Payment for New Admissions
7 License Revocation
8 Receivership
9 Provisional License
10 Special Monitor
11 Directed POC
12 Limitation of Certificate
13 Suspension of Certificate
14 Revocation of Certificate
15 Injunction
16 Civil Monetary Penalty
17 TA & Training for Unsuccessful PT
18 State Onsite Monitoring
19 Suspension of Part of Medicare Payments
20 Suspension of All Medicare Payments
21 None
22 Other (Specify) _____
23 Enforcement Action

13. Date of Proposed Action
0 6 2 8 1 1
M MD D Y Y

14. Parties Notified and Dates

	Party	Date
1 Facility	1. 1	0 6 2 8 1 1
2 Complainant	2. 2	0 7 0 6 1 1
3 Representative	3.	
4 Other (Specify) _____		

MM D D Y Y

15. Date Forwarded to CMS RO or Medicaid SA (MSA) (Attach HCFA-2567)
M MD DY Y

Part III - To Be Completed By Component Taking Final Close-Out Action (RO/MSA)

16. Date of CMS/MSA Receipt
M M D D Y Y

17. CMS RO/MSA Action
[ ]
1 None
2 Termination (23-day)
3 Termination (90-day)
4 Intermediate Sanction
5 Move Routine Survey Date Forward
6 Limitation of Certificate
7 Suspension of Certification
8 Revocation of Certificate
9 Injunction
10 Civil Monetary Penalty
11 TA & Training For Unsuccessful PT
12 Cancellation of Medicare Approval
13 Other (Specify) _____
14 Enforcement Action

18. Date of Final Action Sign-off
M M D D Y Y

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145241	A. BUILDING _____ B. WING _____	C 06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA SOUTHBELT HEALTHCARE	101 SOUTH BELT WEST BELLEVILLE, 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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #1141725/ IL53209, 1141724/ IL53207 and 1141720/ IL53203 The Helia Southbelt Healthcare is in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities for this survey.	F 000		

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.

Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

June 28, 2011

Ms. Amy Gibbs, Administrator
Helia Southbelt Healthcare
101 South Belt West
Belleville, Illinois 62220

Reference: Provider #: 145241/0048587
Survey Date: 06/02/2011
Survey Type:
Complaint Investigation:
1141725/IL53209
1141724/IL52207
1141720/IL53203

Dear Administrator:

On June 2, 2011, an inspection was conducted at Helia Southbelt Healthcare by staff of the Illinois Department of Public Health to determine compliance with federal certification requirements for nursing homes participating in the Medicare/Medicaid programs. As a result of that inspection, no deficiencies were identified (See Enclosure #1, CMS Form 2567L.)

If you have any questions concerning this notice, please contact my staff at (217) 782-5180. You may also telephone the Department's TTY number for the hearing impaired at 1-800-547-0466.

Sincerely,

Richard L. Dees

Richard L. Dees, Chief
Bureau of Long-Term Care

Encl: cc:
CMS Regional Office
Illinois Department of Healthcare & Family Services
Illinois Department on Aging
Division of LTC-FO
Business Filings Inc., Registered Agent
File 2
a2/Current-No Cycle/ MW

ILLINOIS DEPARTMENT OF PUBLIC HEALTH 1141725 1141724
Bureau of Long-Term Care

0048587	060211	1141720
LICENSEE ID #	SURVEY DATE	COMPLAINT #

FACILITY: Delia Southwest H.C. CITY: Belleville

TOTAL # IN-HOUSE RES: MEDICARE 076 MEDICAID 086 PRIVATE 032

TYPE	[L] Licensure	[M] Certification	[C] Complaint	[U] Unlicensed

CLASS	[AN] Annual	[SP] Special	SNF/NF ONLY	DD/LIC ONLY
	[IN] Initial	[IC] Incident	[F1] 1st Revisit	[FC] 45-Day/Cond
	[P1] 1st Prob	[OI] Orig Invest	[F2] 2nd Revisit	[PV] Can Clause/PLV
	[P2] 2nd Prob	[TC] 23-Day/Cond	[FO] Other Revisit	[FU] Follow-Up
	[RE] ReEntry	[PV] Lic PLV		[DD] DD IOC

DISCIPLINE	[N] Nurse	[S] Sanitarian	[D] Dietitian	[Q] QMRP	[A] Architect

TYPE: C CLASS: OI DISC: S

RECEIVED
JUN 09 2011
LTC
CENTRAL OFFICE

SURVEYOR ID & TIME SPENT [Do not complete if HCFA 670 included.]

SURVEYOR ID NUMBER	ENTRANCE DATE	EXIT DATE	OFF SITE HOURS	ON SITE HOURS	TRAVEL HOURS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

SURVEYOR ID NUMBER	ENTRANCE DATE	EXIT DATE	OFF SITE HOURS	ON SITE HOURS	TRAVEL HOURS
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

COMMENTS

OMBUDSMAN CONTACTED? _____ **[NAME]**
DATE ___/___/___ **TIME** _____:_____ **AM / PM** **SURVEYOR INITIALS** _____

LTC07201 ILLINOIS DEPARTMENT OF PUBLIC HEALTH 06/30/11
SNF/NF SURVEY PROCESSING LOG

NAME: HELIA SOUTHBELT HEALTHCARE LIC #: 0048587
STR: 101 SOUTH BELT WEST MED #: 14-5241
CITY: BELLEVILLE 62220 FAC #: 6003255
REGION: 4

LICENSEE INFO: HELIA SOUTHBELT HEALTHCARE, LLC
600 SOUTH SECOND ST., STE. 103
SPRINGFIELD IL 62704
ADMIN NAME: GIBBS,AMY
REG. AGENT: BUSINESS FILINGS INCORPORATED

TYPE/CLASS: C OI _ __ _ __ _ __ _ __ _ __ LEAD COMP #: 1141720

WORKER #/DISC: 05399 S _____ _ _____ _ _____ _ _____ _ _____ _
_____ _ _____ _

IMMEDIATE JEOPARDY ABATED : _____ ND-NO DEFICIENCIES
HIGHEST LEVEL SCOPE/SEVERITY: _ TAG NUMBER: ____ SUB-STANDARD QUALITY/CARE: N
2567 DUE : 06/05/11 RECEIVED: _____ REVIEWER : 29928
10 DAY NOTICE DUE : 06/12/11 SENT : _____ LAST NAME: WATSON, MARTHA
5 DAY PACKAGE DUE: 06/07/11 RECEIVED: _____ SENT : 06/30/11
DATE CERTAIN : _____ 60 DAY : _____ 70 DAY : _____
90 DAY : _____ 180 DAY : _____

EXIT DATE: 06/02/11 COMPLAINT #"S-V/NV:

1141720 NV
1141724 NV
1141725 NV

Viol 0

____ ADMINISTRATIVE REVIEW AA____ RAA____ FINDINGS SENT:_____
____ ARTICLE II A____ RA____ COMMENTS RECD:_____
____ INVOLUNTARY TRANSFER OR DISCHARGE B____ RB____ VIOLATIONS SENT:_____
C____
W____ RW____

COMMENTS: NO findings

REVIEWER: Martha Watson ID#: 29928 DATE: 7/6/11

NO WAIVERS OR WAIVER ACTIONS ON FILE FOR THIS FACILITY

HELIA SOUTHBELT HEALTHCARE
HELIA SOUTHBELT HEALTHCARE
HELIA SOUTHBELT HEALTHCARE