STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Carbondale	120 North Tower Road Carbondale, IL 62901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to assess adaptive equipment and pressure alarms in order to ensure safety and freedom for normal movement for 4 of 4 residents (R3, R5, R9, R18) reviewed for physical restraints in the sample of 26. Findings include:1. R5's “admission Record” documents an admission date of 7/17/25 and a discharge date of 8/25/25 with the following diagnoses in part; other frontotemporal neurocognitive disorder, frontotemporal dementia, dementia in other diseases classified elsewhere, unspecified severity, with agitation, history of falling, muscle weakness (generalized), difficulty in walking. R5's care plan documents that R5 is at risk for falls related to dementia, impaired cognition/safety awareness, use of antidepressant, antianxiety medications, history of falls, impaired gait/balance. This same document lists the following interventions, Lap [NAME] (positioning device) to be ordered and placed on delivery, until arrives staff to increase monitoring, with an initiation date of 7/31/25. Bed alarm on while in bed to notify staff of need for assistance, with an initiation date of 7/17/25. R5's medical record did not contain a restraint assessment for positioning device (lap [NAME]). R5's medical record did not contain an order for a positioning device. On 9/9/25 at 10:43am, V22 (Certified Nursing Assistant/CNA) stated that R5 was a [NAME], and she was strong, it was possible she could remove the velcro off the lap [NAME], but it was not something she could do on command or knew what she was doing. On 9/9/25 at 11:17am, V32 (Therapy Director) stated she can give recommendations for positioning devices, but she does not see too many residents in therapy because most of them are Medicaid and screening them for such devices is not something she regularly does. V32 stated that she worked with R5 right before she really declined. V32 stated R5 was physically very strong, she would get a grip on something, and you could not get it away from her. V32 stated R5 could walk, but she was not steady standing on her own and had some falls. V32 stated that R5 physically had the strength to remove the Velcro on her positioning device, but she did not think she could intentionally remove it. 2. R18's “admission Record” documents an admission date of 4/30/2022 with the following diagnoses in part, unspecified dementia, moderate, with other behavioral disturbance, personal history of traumatic brain injury, and epilepsy, unspecified, not intractable, without status epilepticus. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18's care plan documents that R18 is at risk for falls related to confusion, unsteady gait, use of w/c (wheelchair) for mobility, use of antidepressant and anti-anxiety medication, frequently incontinent of bowel and bladder. Has diagnosis of Dementia, TBI (Traumatic Brain Injury), Seizure disorder. Has poor safety awareness, BLE (Bilateral Lower Extremity) weakness. Attempts to transfer self/ambulate without assistance. This same document lists the following intervention, Trial lap buddy, order lap [NAME]. R18's medical record did not contain a restraint assessment for positioning device. On 9/4/25 at 1:43pm, R18 was not interviewable. R18 was observed in his wheelchair with a positioning device applied on lap. R18 was asked if he was able to remove positioning device. R18 pointed at positioning device, but after several attempts, did not seem to understand instructions. R18 was not able to demonstrate that he is able to remove positioning device on his own. On 9/4/25 at 2:04pm, V34 (Minimum Data Set (MDS) Coordinator) stated they do not do restraint assessments because they do not have restraints here. V34 stated R5 and R18 did not have restraint assessments for the lap huggers (positioning device), and they do not have to assess the residents because when they stand the Velcro releases. 3. R3's admission Record documents a date of birth is 2/14/1944 and an admission date of 9/26/24. This same document lists the following diagnosis: unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing, aphasia following cerebral infarction, diabetes mellitus with diabetic polyneuropathy, and muscle weakness. R3's most recent Minimum Data Set, dated [DATE] documents R3's had a BIMS score of 99, indicating R9 could not complete the interview. Section P that a bed and chair alarm is used daily. R3's Care Plan documented a focus are for risk for falls with interventions in place that included: Bed and chair alarm to notify staff d/t (due to) weight bearing status right foot with a date Initiated of 05/05/2025. There was no physician's order or assessment in R3's medical records for any alarms used by R3. On 9/5/25 at 11:45AM, observed V21 (Certified Nurse Assistant/CNA Supervisor) demonstrating R3's wheelchair alarm and bed alarm in place and working. R3 did not say anything when questioned about the alarms. 4. R9's face sheet documents a date of birth is 5/28/51 and an admission date of 3/20/24. This same document lists the following diagnosis: anxiety, depression and altered mental status. R9's most recent quarterly Minimum Data Set, dated [DATE] documents R9 has a BIMS score of a 10 documenting R9 is moderately cognitively impaired. Section P documents that a bed alarm is used daily. R9's care plan documents a focus area of R9 is at risk for falls related to use of anti-depressant, PRN (as needed) opioid use, requires assist of transfers and is incontinent of bowel and bladder. The goal for this area is to have falls/injuries minimized through management of risk factors while maintaining maximum independence/quality of life through next review. The interventions include on 4/4/25 bed alarm to be on when in bed to alert staff of attempting to self-ambulate. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There is no physician's order or assessments for R9's bed alarm located in R9's medical record. On 9/5/25 at 1:00 PM, V1 stated that residents who have chair and bed alarms do not need orders, and they are just decided upon in interdisciplinary meetings as fall interventions. V1 stated that there are no assessments that go along with these alarms, and they are not considered a restraint. On 9/9/25 at 1:56pm, V1 (Administrator) stated they do not have a policy regarding physical restraints.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to use person centered behavior interventions and attempt less restrictive alternative treatments prior to administering as needed psychotropic medications for 1 of 3 residents (R5) reviewed for psychotropic medications in a sample of 26. Findings include:R5's admission record documents an admission date of 7/17/25 with the following diagnoses and a discharge date of 8/25/25 with the following diagnoses in part; other frontotemporal neurocognitive disorder, frontotemporal dementia, dementia in other diseases classified elsewhere, unspecified severity, with agitation, depression, unspecified, and anxiety disorder. R5's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 99, indicating that R5 was not able to complete the interview. Section N-Medications documents that R5 receives antipsychotics on a routine basis only.R5's Care Plan documents R5 uses medications with black box warnings. With interventions including but not limited to: Clonazepam: Combined with opioids may result in profound sedation, respiratory depression, coma and death. Limit dosages to the minimum required and follow patients closely for signs and symptoms of respiratory depression and sedation. Initiated: 8/4/25.Escitalopram: Increased risk of suicidal thinking and behavior in children, adolescents, and young adults. Risk must balance with clinical need. Reduction in suicidal risks in adults 65 and older. Date initiated:8/4/25. Haloperidol: Increased mortality in elderly patients with dementia-related psychosis. Not approved for patients with dementia related psychosis. Date Initiated: 8/4/25. R5's Care plan documents a focus of: demonstrates significant mood distress/depression related to depression diagnosis, with interventions including but not limited to; Emphasize relation skills to help increase coping. Focus on strengths and accomplishments to help R5 minimize dwelling on problems and perceived failures. Promote self-talk. Help R5 identify negative self-talk and its role in sustaining depression. R5's Care plan documents a focus of: has a history of aggressive, inappropriate, combative behavior, with a diagnosis of anxiety, with interventions including, but not limited to; communicating assertively that R5 must exercise control over impulses and behavior. Remind R5 of inappropriate behavior.R5's Care plan/behavior tracking records documents R5 will reduce combative behavior to zero weekly throughout the review. With interventions including, 1. Anticipate her needs and meet them timely. 2. Check often to see if she needs care, such as toileting or a drink. 3. Remind R5 we are here to help, and she is safe.R5's Care plan/behavior tracking records documents R5 will reduce signs and symptoms of anxiety with behavior disturbances to two times per week through next review. With interventions including, 1. Allow to express feelings and concerns. 2. Encourage to participate in activities. 3. Remind R5 we are here to help her, and she is safe.R5's Care plan/behavior tracking record documents that R5 will reduce signs and symptoms of depression to two times per week throughout the next review. With interventions including, 1. Allow to express her feelings/concerns. 2. Encourage to participate in activities. 3. Remind R5 we are her to help her, and she is safe.R5's Physician Order Sheet document an order for the following scheduled medications: Clonazepam oral tablet disintegrating tablet, give 0.5mg (milligram) tablet by mouth related to dementia, classified elsewhere, unspecified severity, with agitation, anxiety disorder, unspecified. Escitalopram Oxalate Oral tablet 10mg, give one 10mg by mouth one time a day related to depression, unspecified. The start date for both medications was 7/17/25. R5's Physician Order Sheet document an order for the following as needed medications: Clonazepam oral tablet 0.5mg, give 0.5mg as needed for anticonvulsant. Haloperidol Lactate Injection Solution, inject 5mg intramuscularly every 24 hours as needed for agitation, with a start date of 7/17/25. Haloperidol Lactate Injection Solution, Inject 5mg intramuscularly every 24 hours as needed for agitation, with a start date of 7/21/25 and an end date of 8/4/25. Haloperidol Oral Tablet 1mg, give 1mg by mouth as needed for agitation. Take 1mg nightly as needed for agitation, with a start date of 7/21/25 and an end date of 8/4/25. Haloperidol Oral Tablet 1mg, give 1mg by mouth as needed for agitation. Take 1mg nightly as needed for agitation, anxiety related to anxiety disorder, unspecified with a start date of 8/8/25 and an end date of 8/21/25. Hydroxyzine HCl oral tablet 25mg, give 25mg by mouth every 8 hours as needed for anxiety for 14 days, with a start date of 7/21/25 and end date of 8/4/25. Hydroxyzine HCl oral tablet 25mg, give 25mg by mouth every 8 hours as needed for agitation, anxiety related to anxiety disorder, unspecified. With a start date of 8/8/25 and end date of 8/21/25.R5's July Medication Administration record documents R5's as needed dose of Clonazepam was administered on 7/19/25 at 11:27am and 7/21/25 at 9:31pm.R5's July Medication Administration record documents R5's as needed Haloperidol Lactate Injection was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure timely treatment and care in accordance with professional standards of practice after a fall for 1 (R1) of 3 residents in a sample of 26. This failure resulted in R1 not getting immediate treatment for a hip fracture after a fall. A reasonable person would experience feelings of discomfort and distress due to not receiving timely after fall care. This past noncompliance occurred between 8/25/25 and 8/26/25. Findings include: R1's admission Record documented an admission date of 4/27/2023 and diagnoses including chronic obstructive pulmonary disease, unspecified, gastrostomy status, dysphagia, unspecified, schizoaffective disorder, bipolar type, muscle weakness and moderate protein-calorie malnutrition.R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 07, indicating R1 had severe cognitive impairment. This same document under section GG0120 Mobility Devices documented a walker used for ambulation and section I5600 Active Diagnosis documented a diagnosis of malnutrition (protein or calorie) or at risk for malnutrition. R1's Final Incident Report dated 8/25/2025 with time of incident documented R1 had an unwitnessed fall in his room. R1 ambulated independently with walker at baseline. R1 reported pain to right groin with imaging ordered in house. Imaging obtained on 8/26/2025 with results showing a displaced fracture to right femoral neck. R1's Progress note dated 8/25/2025 at 1:24 PM by V15 (LPN) documented heard R1 yelling out. Upon entering room, resident was on the floor, leaning on his right elbow, walker to his left side with no injuries noted, but complain of right inguinal and thigh pain.R1's Progress note dated 8/26/25 at 4:15 PM documents, EMS (Emergency Medical Services) arrived and transferred R1 to the local hospital. On 9/3/2025 at 12:51 PM, V18 (Certified Nursing Assistant/CNA) stated, she did work on 8/25/2025 when R1 had fallen in his room. V18 stated, she heard R1 hollering out from his room while she had been at the nurse's station. V18 stated, she went into R1's room with V24 (CNA) and found R1 on the floor. V18 stated, she requested V15 (Licensed Practical Nurse/LPN) to come to R1's room. V18 stated, V15 assessed R1 with V24 and then helped him back to bed. V18 stated, R1 had been complaining of pain in his groin area and unable to stand or do baseline activities. V18 stated, she notified V15 of R1's not being able to perform his normal functions multiple times after his fall and V15 stated, R1 would have to wait. V18 stated, no imaging was completed the day of the fall.On 9/3/2025 at 1:02 PM, V15 (Licensed Practical Nurse/LPN) stated, she had been working the day R1 had his fall event on 8/25/2025. V15 stated, V18 (CNA) and V24 (CNA) requested for her to come to R1's room. V15 stated, R1 had been on his right side in the floor when she entered his room. V15 stated, R1 had been helped back to bed by her and V24, she then notified V16 (Family) and V17 (Physician) of R1's fall. V15 stated, V17 ordered imaging pictures be taken of R1's right hip related to pain from the fall. V15 stated, she contacted the imaging company to schedule them to come to the facility for pictures. V15 stated, the imaging company returned a call and notified her that they would not be able to come to the facility until the next day. V15 stated, she did not notify the doctor that the imaging company could not come that day. V15 stated, R1 did still have pain throughout her shift and was unable to complete his baseline activities. V15 stated, she had been back to R1's room several times that day to see if he wanted to get out of bed. V15 stated, R1 probably should have been sent to the local emergency room for further evaluation that day after the imaging company could not complete the order, but she did not send him. On 9/4/2025 at 11:09 AM, V2 (Assistant Director of Nursing/ADON) stated, she had been notified that R1 had fallen on 8/25/2025 in the afternoon. V2 stated, she thinks R1 had been reaching for his crayons when he fell out of bed. V2 stated, per V15's (LPN) nursing note documented R1's fall, with notifications to V17 (Physician) and V16 (Family) and order for imaging pictures to be performed. V2 stated, on 8/26/2025 around 4:00 PM the imaging company arrived in the facility to complete imaging pictures for R1 and R1 had still been in pain after pictures were taken, so she contacted V16 (Family) via phone to discuss sending R1 to the hospital for further evaluation. V2 stated, V16 agreed to have R1 sent to the local emergency room. V2 stated, R1 was transferred to the local hospital by ambulance around 4:15 PM on 8/26/2025. V2 stated, the imaging order for R1 should have been initially order stat (immediate) and if the imaging company could not come out to complete the pictures then V16 (Family) should have been contacted to discuss further evaluation which would include R1 being sent to the local hospital. On 9/4/2025 at 11:24 PM, V28 (Imaging Company) stated, there is documentation on 8/25/2025 at 1:37 PM for R1 to receive an image order to the right hip. V28 stated, the order was not ordered stat (immediate). V28 stated, around 4:30 PM the technician on 8/25/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess and provide pain medication after a fall for 1 (R1) of 3 residents reviewed for pain in a sample of 26. This failure resulted in R1 not receiving any pain medication for a hip fracture for several hours after a fall. A reasonable person would experience feelings severe pain and discomfort due to not receiving pain relief medication. This past noncompliance occurred between 8/25/25 and 8/26/25. Findings include:R1's admission Record documented an admission date of 4/27/2023 and diagnoses including chronic obstructive pulmonary disease, unspecified, gastrostomy status, dysphagia, unspecified, schizoaffective disorder, bipolar type, muscle weakness and moderate protein-calorie malnutrition.R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 07, indicating R1 had severe cognitive impairment.R1's Physician Order Summary documented Acetaminophen Oral Suspension. Give 5 ml via gastrointestinal tube every 6 hours as needed for mild pain related to muscle weakness (generalized) with a start date of 07/22/2024.R1's Progress note dated 8/25/2025 at 1:24 PM by V15 (Licensed Practical Nurse/LPN) documented heard R1 yelling out. Upon entering room, resident was on the floor, leaning on his right elbow, walker to his left side with no injuries noted, but complain of right inguinal and thigh pain.R1's Final Incident Report dated 8/25/2025 with time of incident documented R1 had an unwitnessed fall in his room. R1 ambulated independently with walker at baseline. R1 reported pain to right groin with imaging ordered in house. Imaging obtained on 8/26/2025 with results showing a displaced fracture to right femoral neck.The local Hospital emergency room imaging report for R1's right hip related to fall with pain and unable to weight-bear, dated 8/26/2025 documented an acute fracture of the right femoral neck with acute angulation.On 9/3/2025 at 12:51 PM, V18 (Certified Nursing Assistant/CNA) stated, she notified V15 (Licensed Practical Nurse/LPN) of R1's continued pain and not being able to perform his normal functions multiple times after his fall. V18 stated, V15 stated to her, R1 would have to wait. On 9/5/2025 at 10:32 PM, V15 (LPN) stated she did not give any pain medication to R1 after his fall event on 8/25/2025 or during her shift that day.On 9/5/2025 at 12:27 PM, V16 (Family) stated R1 did have a fall on 8/25/2025. V16 stated at the time of the fall when they contacted him, R1 had been having pain in his right groin/inner thigh. V16 stated, he came to visit R1 on 8/26/2025. V16 stated, R1 told him he was in pain when he asked him if he was hurting by pointing to his right inner thigh/groin area. V16 stated, he would assume that the facility would give R1 pain medication as ordered.On 9/4/2025 at 11:09 AM, V2 (Assistant Director of Nursing/ADON) stated she had been notified that R1 had fallen on 8/25/2025 in the afternoon. V2 stated, on 8/26/2025 around 4:00 PM the imaging company arrived in the facility to complete imaging pictures for R1 and R1 had still been in pain, so she contacted V16 to discuss sending R1 to the hospital for further evaluation. V2 stated, V16 agreed to have R1 sent to the local emergency room. V2 stated, R1 was transferred to the local hospital by ambulance around 4:15 PM. V2 stated, R1 had no documentation of pain medication given until Acetaminophen Oral Suspension (Acetaminophen) 5 milliliters for 8/10 pain on 8/26/2025 at 10:59AM.On 9/5/2025 at 1:28 PM, V17 (Physician) stated, he had been notified of R1's fall event from 8/25/2025. V17 stated, around 1:37 PM he received a text message to order imaging of the right hip for R1. V17 stated, he had not been notified of a pain assessment for R1, that R1 could not bear-weight or there was a delay in imaging. V17 stated, V15 (LPN) should have completed a better assessment of R1 after his fall event. On 9/9/2025 at 10:13 AM, V24 (Director of Nursing/DON) stated she had been notified on 8/26/2025 that R1 had a fall event the day before and she went down to assess R1. V24 stated, R1 did have pain to his right lower leg upon assessment. V24 stated, she requested for R1 to be administered pain medication while she contacted the imaging company to follow up on R1's order. V24 stated, pain should be assessed for all residents who have had a fall and R1 should have received pain medication with verbalizing pain to his right hip.R1's August Medication Administration Record (MAR) documented no pain medication was given on 8/25/2025. R1's MAR documents R1 received Acetaminophen Oral Suspension (Acetaminophen) 5 milliliters for 8/10 pain on 8/26/2025 at 10:59AM.The facility's Pain Management Policy (adapted/revised 2022) documented under Purpose: To facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. General Guidelines: The facility will achieve these goals through: Promptly and accurately assessing and