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	10/09/2025

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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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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F 0558 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 observation, interview, and record review the facility failed to promote independence and autonomy with toileting by neglecting to utilize an available room with a functioning toilet for 1 (R40) of 3 residents reviewed for reasonable accommodation of needs/preferences in a sample of 46. Findings include:R40's admission Record documented an admission date to the facility on 7/7/25 and included diagnoses of Alzheimer's disease, dementia, anxiety disorder, and cognitive communication deficit. R40's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99, indicating the BIMS assessment was unable to be completed. On 9/22/25 at 4:00 PM, V36 (Family Member) stated the bathroom in R40's room did not work from the time she was admitted there in early July of 2025. V36 stated R40 was able to take herself to the bathroom when she needed to go, but since the restroom was out of order in her room she would get confused and urinate in odd places. V36 stated she had urinated in laundry baskets, in the floor, and in trashcans while residing in that room. V36 stated since being moved to another room with a properly functioning toilet she has not gotten any reports of R40 urinating in inappropriate places. On 9/24/25 at 4:28 PM, V20 (Certified Nursing Assistant/CNA) stated R40 previously resided on South Hall. R40's previous room was observed on this date and time to be empty, but the attached [NAME] and Jill bathroom was observed to have the door closed with a locked padlock in place. This bathroom was shared with the room next to R40's, which was also empty on this date and time. V20 stated when R40 resided in this room, she would at times use the communal bathrooms down the hallway, but she would get lost or confused trying to find them and staff would have to show her to the communal bathroom. Surveyors noted two communal bathrooms on the South Hall that each had a shower stall and toilet/sink. On 9/25/25 at 9:49 AM, V2 (Director of Nursing) stated the residents that previously resided in the room next to R40's, where the shared bathroom was located, were dependent on staff for transfers and care, so they did not independently get up to use that restroom. In addition, R40's roommate was also dependent for care and didn't independently use that restroom. V2 stated R40 could get up to use the restroom but when that toilet stopped working and when R40 got covid, V2 talked to R40's family about using a bedside commode so she could remain close to the nurse's station and V2 said family was agreeable to that. V2 stated she did not have any knowledge of R40 being incontinent in inappropriate places. V2 stated she didn't think about moving the resident to a room with a working bathroom because she wanted to keep R40 close to the nurse's station. V2 stated R40 was in the room with a nonfunctioning toilet from admission until she was moved recently. Progress note dated 9/16/25 at 11:02 AM, documents Contacted (Name of family) informed that (R40) is being moved to North Hall (room number). She only asked that all her belongings be moved with her. No other concerns. On 9/25/25 at 9:43 AM, the shared restroom attached to R40's previous room was observed to have a clogged toilet. V6 (Maintenance Director) stated the bathroom toilet wasn't working and thinks it had not been functional since sometime in July due to a previous resident stuffing paper towels down it. V6 stated he plans to have the plumbing company look at it when they come to address the plumbing issues in the kitchen. On 9/25/25 at 12:09 PM, V20 (CNA) stated when she started working at this facility, which was in the beginning of August of 2025, R40 already had a bedside commode in her room. V20 stated R40 would get confused because she couldn't use the bathroom in her room and would urinate in the floor. V20 stated R40 urinated in the corner of her room one time and R40 used her wig to mop it up. V20 stated R40's bathroom was locked due to not functioning properly from the time she started working at this facility until R40 was moved to a different room. V20 stated since R40 was moved to a different room with a working bathroom she uses the bathroom in her room without any issues and has not urinated or defecated in the floor. On 9/25/25 at 12:13 PM, V26 (CNA) stated R40 was admitted to the room with the nonfunctioning toilet when she first came to the facility. V26 stated R40 had a bedside commode in her room because the bathroom in her room was not functioning properly, and the door was padlocked so R40 could not get into it. V26 said R40's room was connected to the room next door via a shared bathroom. V26 stated the bathroom door on R40's side was locked so she could not enter it from there, but it was not locked on the adjoining side so it could be entered from that room. V26 stated at one point, R40 got confused trying to find a bathroom so she went to the room next to hers that shared the adjoining bathroom, went into the bathroom and defecated and urinated onto a plastic cover that was covering the toilet due to it not being operational. V26 stated R40 also defecated in her closet at one point. V26 stated since R40 has been moved to the North Hall with a properly

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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 0627 Level of Harm - Actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop individualized discharge plans that incorporated input and preferences from the resident, resident representative, and the interdisciplinary team to ensure safe and orderly transfer/discharge planning for 13 (R13, R14, R17, R18, R21, R22, R23, R24, R25, R27, R28, R30, and R31) of 27 residents reviewed for transfer and discharge in the sample of 46. This failure resulted in R27 and R30 experiencing feelings of upset/worry, sadness, or distress and would cause a reasonable person to feel the same emotions when given the news of having to relocate to another facility on very short notice. Findings include:On 9/15/25 at 1:35PM, V1 (Former Administrator) provided a list of residents still in the facility and stated there were still 19 in house as of this date/time. V1 said they have provided the IDPH (Illinois Department of Public Health) regional office a list of those residents that have been discharged to date and plan to send weekly updates. V1 said the list includes resident names, the location they were transferred to and the date/time they left. V1 stated the facility has plumbing issues that need addressed and the kitchen will need to have 3 feet of concrete dug up in order to replace old cast iron plumbing that has collapsed. V1 stated other areas of the facility's physical environment need remodeled as well, such as paint and flooring in some areas and they also plan to do those repairs while the kitchen plumbing is being replaced. V1 stated it's her understanding the facility owner plans to reopen the facility after repairs are complete and residents can return after completion. V1 stated the residents that have transferred out thus far have all gone to other homes owned by (name of facility's corporation) but they were given choices of where they wanted to go. V1 admitted that the facility did not provide written notices, however no residents were forced to go somewhere they did not want to go and all that have transferred agreed with their new placement. V1 stated the closure is temporary and not an emergency but these repairs do need to be done soon, and residents need to go to other facilities for them to complete the repairs. On 9/15/25 at 2:45 PM, V4 (Ombudsman) stated that he can't remember which day, either late Thursday afternoon (9/11/25) or early Friday morning (9/12/25) that residents were being transferred out of the facility. V4 said V1 (Former Administrator) told him there were plumbing issues that needed fixed, and it would take about 2 months. V4 said that he told V1 that residents need to be given a choice about where they go and V1 stated they were giving them choices. V4 was asked if the facility provided him notice of the resident transfers or temporary closure, and V4 stated no, the facility did not contact him. V4 stated he got word from someone at Adult Protective Services that the facility was transferring people out when they called to inquire about a bed opening, so they called V4 to see if he was aware and he was not. V4 stated he was concerned the facility may not be following proper procedures for transfers/closure or providing the required notices and discharge planning for safe/orderly transfers. On 9/16/25 at 9:31 AM, V1 stated the residents were given a choice of corporate sister facilities first, then if they didn't want that they gave options of other facilities that are close. 1. R27's admission Record documented an admission date to the facility of 8/6/25 and included diagnoses of anxiety disorder and depression. This document lists R27 as her own responsible party, with a daughter listed as an emergency contact. R27's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating R27 is cognitively intact. R27's Care Plan included a Focus area of R27 at times presents with moderate sign/symptoms of anxiety, initiated on 8/13/25 with an intervention of encouraging R27 to talk about anything that may be on her mind, speak in a calm voice and actively listen and offer assistance by asking if there's something staff can do to help. Another Focus Area documents R27 at times demonstrates mood distress d/t (due to) depression, initiated on 8/13/25, with interventions to aid R27 in decreasing of hopelessness by including her with decision making, provide positive feedback, encourage expression of feelings, especially related to area of life outside of R27's control and communicate care, empathy, sensitivity and compassion for the resident and what she is going through. R27 also has a Focus area documenting she is alert and oriented x (times) 3 and is able to make needs known without difficulty, with an intervention to communicate with family/caregivers regarding capabilities/needs. R27 has a Focus area that she intends to be short term and return to community with support services after receiving therapy 6/8 months with an intervention that SSD (Social Service Director) will provide/assist R27 with information and/or applying for community resources/support services. R27's Care Plan did not include any updates or revisions to indicate planning for transfer or discharge, including a plan for therapy services, to another facility had occurred. A discharge MDS documented R27 was

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide residents and/or their representatives timely written notification of the reason for transfer out of the facility and failed provide notice to the Ombudsman of resident transfers for 9 (R21, R22, R23, R24, R25, R27, R28, R30, R31) of 9 residents reviewed for discharge process in the sample of 45. On 9/15/25 at 1:35PM, V1 (Former Administrator) provided a list of residents still in the facility and stated there were still 19 in house as of this date/time. V1 said they have provided the IDPH (Illinois Department of Public Health) regional office a list of those residents that have been discharged to date and plan to send weekly updates. V1 said the list includes resident names, the location they were transferred to and the date/time they left. V1 stated the facility has plumbing issues that need addressed and the kitchen will need to have 3 feet of concrete dug up in order to replace old cast iron plumbing that has collapsed. V1 stated other areas of the facility's physical environment need remodeled as well, such as paint and flooring in some areas and they also plan to do those repairs while the kitchen plumbing is being replaced. V1 stated it's her understanding the facility owner plans to reopen the facility after repairs are complete and residents can return after completion. V1 stated the residents that have transferred out thus far have all gone to other homes owned by (name of facility's corporation) but admitted that the facility did not provide written notices. V1 stated the facility closure is temporary and not an emergency but these repairs do need to be done soon, and residents need to go to other facilities for them to complete the repairs.On 9/15/25 at 2:45 PM, V4 (Ombudsman) stated that he can't remember which day, either late Thursday afternoon (9/11/25) or early Friday morning (9/12/25) that residents were being transferred out of the facility. V4 said V1 (Former Administrator) told him there were plumbing issues that needed fixed, and it would take about 2 months. V4 said that he told V1 that residents need to be given a choice about where they go and V1 stated they were giving them choices. V4 was asked if the facility provided him notice of the resident transfers or temporary closure, and V4 stated no, the facility did not contact him. V4 stated he got word from someone at Adult Protective Services that the facility was transferring people out when they called to inquire about a bed opening, so they called V4 to see if he was aware and he was not. V4 stated he was concerned the facility may not be following proper procedures for transfers/closure or providing the required notices and discharge planning for safe/orderly transfers. V4 confirmed he has not received any written notice of residents being transferred out. 1. R27's admission Record documented an admission date to the facility of 8/6/25 and included diagnoses of anxiety disorder and depression. This document lists R27 as her own responsible party, with a daughter listed as an emergency contact. R27's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating R27 is cognitively intact. A discharge MDS documented R27 was discharged from the facility on 8/31/25 for a short-term hospital stay. R27's Progress Note on 9/4/25 at 10:49AM, labeled a Social Service Note, documented V1 (Former Administrator) contacted (R27's) daughter to discuss sending a referral to a sister facility due to this facility not currently receiving payment for medicaid/medicare. She was agreeable to the transfer and would like her to return to this facility when possible. On 9/5/25 at 10:26AM documented Resident left facility with bus driver from (name of sister facility located approximately 20 miles east of original facility). All meds (medications) and belongings sent with driver.Report called to nurse on duty at (sister facility). The medical record does not include evidence of facility staff having any direct conversation or discussion with R27 regarding her preferences or options of available locations for transfer, nor any evidence that a 30-day written notice of transfer was provided to R27. R27's Receiving Facility admission Record documented an admission date to the receiving sister facility (approximately 20 miles east of the original facility) on 9/5/25 and also listed R27 as her own responsible party. On 9/16/25 at 4:30 PM, R27 was observed in the new/receiving sister facility and was alert and oriented to person, place and time. R27 stated when she was at the original facility, about a week or more ago, she had to be sent out to the hospital and was supposed to go back to that facility after being discharged from the hospital. R27 said she discharged from the hospital on Wednesday (9/3/25) or Thursday (9/4/25) and went back to the facility for a day or so but on Friday (9/5/25) staff there told her she couldn't stay there because they couldn't take any new admissions, so she had to come here (to the sister facility). R27 said she came here to the new facility on the same day she was told about not being able to stay at the previous facility. When asked if R27 was given any other reason for her transfer, such as plumbing issues or

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 a resident's bed was in the lowest position and the fall mat was in place on the floor next to the bed for 1 (R42) of 3 residents reviewed for falls in a sample of 46. This failure resulted in R42 falling out of a high bed with no floor mat beside the bed and sustaining multiple dark purple contusions to her face, neck, wrist, hand, and forearm, swelling to her eye, eyebrow and forehead area, along with skin tears to the right forearm and left hand. This past non-compliance occurred between 9/1/25 and 9/1/25. Findings include: This past non-compliance occurred between 9/1/25 and 9/1/25. Findings include:R42's admission Record documented an admission date of 1/5/22 and a discharge date of 9/3/25 and included diagnoses of dementia, cognitive communication deficit, weakness, unsteadiness on feet, chronic pain, and low back pain.R42's Minimum Data Set, dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 99, indicating the BIMS assessment was unable to be completed. R42's Care Plan documents R42 is a fall risk with interventions including in part, bed alarm while in bed, floor mat next to bed and R42 needs a safe environment with even floors free from spills and/or clutter, adequate glare-free light, a working and reachable call light, the bed in low position at night, handrails on walls, personal items within reach.R42's progress note dated 9/1/25 at 1:20 AM documented Roommate yelled for staff to come into the room. Upon entering the room, (R42) was noted lying on the floor beside her bed, face down. Three staff assisted (R42) to turn over onto another blanket and she was then lifted back onto the bed. (R42) stated, I rolled out of the bed and landed on my face. (R42) had a 4cm (centimeter) straight skin tear on her right forearm that was cleansed and closed with steri strips. (R42) had a 6cm by 2cm skin tear on her left hand that was cleansed and closed with steri strips. (R42) had a contusion on each side of her forehead, larger on right side. Neuro (neurological) checks were initiated. (R42) is alert and able to communicate with staff. Pupils are equal and reactive to light. Tongue is midline.R42's progress note dated 9/1/25 at 4:29 AM documents Fall mat placed beside bed. Staff reminded to lower bed to lowest position when leaving the room. R42's progress note dated 9/1/2025 at 3:17 PM documents in part R42's right eye is swollen following her fall. R42's Risk Management document dated 9/1/2025 at 1:00 AM documents under Nursing Description: Roommate called out for staff. Entering the room, (R42) was noted laying facedown on the floor beside her bed. Under Description of Action Taken: This nurse was joined by two CNA's (Certified Nursing Assistants) and (R42) was rolled onto her back onto another blanket and lifted back into bed. She (R42) was assessed for injury. Staff to insure [sic] that bed is in it's [sic] lowest position when leaving the room. Mat placed beside bed.On 9/23/25 at 1:14 PM, V22 (Family/POA) stated she received a call from V28 (License Practical Nurse/LPN), the nurse that was working when R42 fell, stating R42 had fallen out of bed. V22 stated she was told the bed was left in the high position and there was no fall mat beside the bed so R42 had fallen directly on the floor, face first, out of a high bed. V22 stated R42 was not taken to the hospital. V22 stated V28 told her R42 wasn't that bad but she looks pretty banged up and did not ask her if she wanted R42 sent to the hospital for evaluation. V22 stated R42's roommate saw her fall and yelled for help. V22 stated they moved R42 to a different facility after this fall because she needed to get her out of that facility before they killed her. V22 stated R42 has been less alert and has not acted right since the fall and had some pain in her face and head after the fall for several days. V22 provided photographic evidence of R42 after her fall. V22 confirmed that the time stamp on each photo is correct. V22 stated the photos taken on 9/1/25 were taken at (name of facility) and the photos taken on 9/4/25 were taken at the facility R42 was transferred to after her fall. On 9/24/25 at 9:54 AM, V29 (CNA) stated she was working the night R42 fell out of bed. V29 stated she found R42 laying on the floor beside her bed. V29 stated the bed R42 fell out of was too high, it wasn't in the low position. V29 stated she was the only CNA working on that hallway at the time and she must have forgotten to put her bed back down to the low position after providing care. V29 stated the fall mat was not beside the bed, it was pushed under the bed. V29 stated she was very overwhelmed at that time because she was the only CNA on that hallway. V29 stated she was educated on lowering the bed when she is finished with care and putting the fall mat in place.On 9/25/25 at 9:25 AM, V28 (LPN) stated she was sitting at the nurse's station when a CNA came and got her saying R42 had fallen out of her bed. V2 stated when she entered the room R42 was laying directly on floor beside the bed and the bed was in a position that was close to the highest position. V28 stated she doesn't remember where the fall mat was, but it wasn't beside the bed because R42 fell directly beside her bed and landed on the floor. V28 stated she educated all the