

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145863	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Integrity Hc of Marion		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 East Deyoung Marion, IL 62959	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666</p> <p>Based on interview and record review, the facility failed to ensure resident's medications were administered per facility policy for 1 (R1) of 3 residents reviewed for medication administration in the sample of 7.</p> <p>This past noncompliance occurred from 1/14/25 to 1/15/25.</p> <p>The findings include:</p> <p>R1's Admission Record document R1 was admitted to the facility on [DATE]. The same document lists some of R1's diagnoses as nondisplaced fracture of Lateral Condyle of Right Tibia, Restless Leg Syndrome, and Fibromyalgia.</p> <p>R1's MDS (Minimum Data Set), dated 1/16/25, documents R1 has a BIMS (Brief Interview of Mental Status) of 15, which indicates R1 is cognitively intact.</p> <p>R1's Order Summary Report, dated 1/14/25, documents a Physician's orders for the following: Diphenhydramine (Benadryl) 50 mg (milligrams) Give 1 tablet every 4 hours for itching and Ropinirole HCL ER (Extended Release) 2 mg Give 1 tablet by mouth at bedtime for RLS (Restless Leg Syndrome).</p> <p>Untitled Facility Document noting Physician Standing orders document for minor pain/fever Acetaminophen 1000 mg q8h (every 8 ours) prn (as needed) for pain, fever, headache-call if fever is greater than 101.4 degrees Fahrenheit.</p> <p>R1's MAR (Medication Administration Record) documents on 1/15/25 at 1:47 am, V7 (RN/Registered Nurse) gave R1 Diphenhydramine 50 mg by mouth. There was no documentation on the MAR that Acetaminophen was given. The same MAR notes Ropinirole 2 mg signed by V7 as a Code 9. The MAR notes a Code of 9 as other/see Nurses Notes.</p> <p>R1's Nurses note, dated 1/15/25 by V7, notes resident alert, oriented, awaiting pharmacy delivery of medications particularly for Restless leg DX (diagnosis), has taken advantage of PRN's for pain & anxiety to settle legs this night. There was no documentation the Physician was notified of R1 not getting the Ropinirole.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/17/25 at 10:30 am, R1 said the facility did an investigation into her being given the wrong meds. She said the nurse came in and asked her if she was R2 and she said yes, and took the meds. She then said her roommate (R2) spoke up and said, I am (R2 (giving her name). R1 said she did swallow them and then tried to spit them back out. She said the nurse said, It's ok, its just Tylenol and Benedryl. R1 said she did not get her Requip (Ropinirole) for her restless leg syndrome.</p> <p>On 1/17/25 at 11:40 am, R2 said it was about 9:30 or so when the incident happened. R2 said she was in her bed but awake. She said she heard the nurse ask R1 if she was R2's first name. R2 said the curtain was pulled between their beds. R2 said she then spoke up and said, I am and said her first name. R2 said the nurse said Oh wait you are not (R2's first name). R2 said the nurse said, Oh it doesn't matter, its just Tylenol and benedryl. R2 said R1 did not swallow the medications.</p> <p>On 1/17/25 at 2:20 pm, V7 (RN/Registered Nurse) said she was working the night of the incident. V7 said she worked from 6pm to 6am on the 400 hall where R1's room was. V7 said there were 2 new admissions that she had never seen. V7 said she had R2's MAR (Medication Administration Record) open. V7 said she entered the room and went to the resident in the first bed by the door and said R2's first name, and R1 said yes, yes so she gave R1 the medications and took a sip of water. V7 said there was 2 Tylenol 325 mg and 1 Benadryl 50 mg in the cup. V7 said she handed R1 the cup, and after they were in her mouth and she took a sip of water, the lady in the next bed said, I am (R2). V7 said R1 did not swallow the medications. V7 said R1 then spit the meds out. V7 said prior to spitting the meds out R1 said, I can spit them out. V7 said the medications were as needed orders, so she wasn't too worried about it. V7 said R1 was asking for her Requip pill and V7 told her it had not arrived from the pharmacy yet. V7 said she did go to the emergency kit and there was no Requip in it. V7 said she did not deem it an emergency, and therefore did not notify the physician the medicine was not available to give.</p> <p>On 1/17/25 at 12:15pm, V1 (Administrator) said she would expect the nurse to notify the physician if a medication was not available, and use 2 identifiers when passing medications.</p> <p>On 1/17/25 at 9:30 am, V2 (DON/Director of Nurses) said R1 was a new resident, and V7 should have used 2 identifiers before giving the medication. V2 also said the physician should have been notified when the medication was not available to give to the resident.</p> <p>Facility Document labeled 5.1: Drug Administration-General Guidelines, dated July 2024, document Residents are identified before medication is administered. a. Check identification band, b. Check photograph attached to medical record, header card, or facility approved location, c. Call resident by name, d. If necessary, verify resident information with other facility personnel.</p> <p>Prior to the survey date, the facility took the following actions to correct the noncompliance: According to the QAPI review on 1/15/25.</p> <p>R1 was assessed on 1/15/25 with no negative outcome noted. IDT team reviewed and discussed in clinical meeting on 1/15/25.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility has educated the licensed nursing staff to notify M.D. of medications not available and using 2 identifiers when identifying residents. You are to ask for their full name and date of birth. Inservice completed for all nursing staff on 1/15/25 on the following: New admissions should have scripts for the listed medications. If you are aware of any issues, delays, or missing medications be sure to communicate with the DON/ADON (Assistant Director of Nursing), pharmacy and family to ensure your residents have all of their medications upon admission. Any additional concerns can be addressed with the Doctor. Be sure to notify him. Also use 2 identifiers when identifying residents during med pass. These consist of Full name and Date of Birth.</p> <p>The Director of Nursing or designee will complete random checks three times a week for four weeks and then weekly for eight weeks to ensure staff is notifying M.D. of medications not available and staff is identifying residents correctly. Three times a week with educational needs will be discussed. The results of the audits will be reviewed in the QA meeting 01/31/2025.</p>		