

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 08/11/2025
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)
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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 1 of 1 (R1) resident reviewed for accommodation of needs in the sample of 19. Findings Include:1.R1's facility admission Record, with a print date of 8/4/25, documents R1 was admitted to the facility on [DATE], with diagnoses that include right femur fracture, generalized anxiety disorder, muscle weakness, and difficulty walking.R1's MDS (Minimum Data Set), dated 7/27/25, documents a BIMS (Brief Interview for Mental Status) score of 15, indicating R1 is cognitively intact.R1's current Care Plan documents a Focus area of, Transferring: (R1) has a self care deficit in transferring r/t (related to) recent fall with R (right) femur fx (fracture), WBAT (weight bearing as tolerated) status to RLE (right lower extremity), and deconditioning. Date Initiated: 07/23/2025. This Focus area includes the intervention of Use adaptive equipment: Standard Walker/Rolling Walker/ Quad Cane/Sliding Board/Gait belt. Date Initiated: 07/23/2025. This same Care Plan documents a Focus area of, (R1) has a R (right) Hip Fracture r/t (related to) a fall at home prior to admission. She had ORIF (Open Reduction Internal Fixation) on 7/19/25 with rod placement. Date Initiated 07/31/2025. This Focus area includes interventions of Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Date Initiated: 07/31/2025.On 07/31/25 at 2:15 PM, R1 was sitting on the edge of her bed, with her wheelchair in front of her. R1 stated she needed assistance swinging her legs onto the bed. There was a bell sitting on the over the bed table located on the opposite side of the bed. R1 was not within reach of the bell and stated she couldn't reach it. R1 stated she had been yelling for assistance and no one had come. R1 stated there was no working call system in her room or in the bathroom. R1 yelled for help at 2:21 PM and stated she had yelled prior to this surveyor entering her room (2:15 PM). R1 stated one time she went to the bathroom and was left sitting on the commode for 30-45 minutes. R1 stated staff would come tell her they were going to assist, leave, and not come back. R1 stated the call system had been down for a while. R1 stated they gave them cheap bells, and no one could hear them, so they gave them cow bells. No staff had responded to R1's yell for assistance, so this surveyor handed her the bell at 2:27 PM. R1 rang the bell and V4 (CNA/Certified Nursing Assistant) responded at 2:28 PM.On 7/31/25 at 2:29 PM, V4 (CNA) stated the call system had been down since she worked on Sunday night (7/27/25). V4 stated she wasn't sure how long they were down prior to her shift. V4 stated they got bells for the residents to ring when they needed assistance, and she takes the bells to the bathrooms with the residents. V4 stated she tried to remind residents who are independent to take their bells with them. V4 stated she can normally hear residents calling for assistance. V4 stated they were doing 15-minute checks on the residents as well.On 8/4/25 at 4:24 PM, V4 (CNA) stated while the call system was down it was more difficult to determine which room needed assistance because they would have to find where the bell was ringing from. V4 stated she had never had to assist R1 with putting her legs in bed until that day, then stated she had assisted R1 with it maybe three other times.On 8/6/25 at 10:53 AM, V24 (CNA) stated when the call system was down the residents would ring the bells. V24 stated they would take the bells with them when they went to the bathroom. V24 stated they made sure the residents had their bell with them most of the time. V24 stated R1 required supervision with transfers because she was unsteady at times.On 7/31/25 at 4:20 PM, V1 (Administrator) stated the call system had been down and they gave all of the residents a bell to use. V1 stated the residents should take the bells with them when they go to the bathroom. When asked how they ensured residents took their bells with them, V1 stated, They have to take them with them.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pain was treated for 1 of 1 (R3) resident reviewed for pain in the sample of 19. This failure resulted in R3 experiencing severe pain with no treatment for the first 24 hours of admission, resulting in a lack of sleep and emotional distress. Findings Include:R3's facility admission Record, with a print date of 8/4/25, documents R3 was admitted to the facility on [DATE], with diagnoses that include sacroiliitis, surgical aftercare, diabetes, asthma, anemia, restless leg syndrome, Alzheimer's disease, and radiculopathy of lumbar region.R3's Baseline Care Plan, dated 7/30/25, documents R3 is alert with cognitive impairment. This Care Plan documents, family states resident gets confused at times. Under Pain, this Care Plan documents R3 is in pain with no pain level documented.R3's Order Summary Report with Active Orders: Percocet Oral Tablet 7.5-325 MG (milligrams).Give 1 tablet by mouth every 6 hours as needed for pain. Start Date 07/30/2025.R3's Medication Administration Record, dated 7/1/25 to 7/31/25, documents a physician order to Monitor and document pain level every shift. Start Date 07/30/2025 1800 (6:00 PM). On 7/30/25 under Pain Level Night and 7/31/25 Pain Level Day, there is an 8, indicating R3 was experiencing pain at an 8 out of 10 level. This same MAR documents a physician order of, Percocet Oral Tablet 7.5-325 MG (milligrams).Give 1 tablet by mouth every 6 hours as needed for pain. Start Date 07/30/2025. There are no signatures indicating R3 received this medication on 7/30/25 or 7/31/25.R3's Progress Notes document the following.7/30/25 10:12 AM, report called from (name of regional hospital) . female with hx (history) of DM (diabetes mellitus), stroke, breast cancer, sleep apnea, Parkinsons, seizures, RLS (restless leg syndrome), liver failure, depression, GERD (gastroesophageal reflux disease), kidney stones. Resident c/o (complaints of) rt (right) leg pain, rx (prescription) for Percocet is being sent. Has lumbar laminectomy on 7/25 with a pain stimulator present.7/30/25 2:30 PM, Resident arrived via family personal car. Resident assisted into bed. Resident is A/O (alert and oriented) x (times) 4 at this time, with family at bedside.7/30/25 4:47 PM, Messaged MD (physician) for RX for Percocet as no scripts came with resident. Hospital stated they sent RX with her. Awaiting response.7/31/25 8:58 AM, Resident c/o pain 8/10. MD notified for PRN (as needed) pain pill Percocet 7.5/325 prn q (every) 6 (hours) signed script.7/31/25 9:53 AM, Tylenol offered for pian. Res (resident) refuses states it won't work. Awaiting response from MD for PRN Percocet script.7/31/25 5:22 PM, Pharmacy contacted for emergency release code for Percocet from (medication cabinet). Medication obtained and administered to patient.On 7/31/25 at 2:49 PM, R3 was laying in her bed covered with blankets. R3 stated she arrived at the facility yesterday morning and hasn't had any pain medication since her arrival. R3 stated she didn't get any medications until about an hour ago. R3 stated last night was rough, no sleep, just sat here crying in the blanket. When asked why she didn't get her medications including her pain medication, R3 stated they didn't get the order from the doctor and couldn't get it from the pharmacy.On 8/6/25 at 10:37 AM, V23 (Certified Nursing Assistant/CNA) stated she provided care for R3 on her day of admission. V23 stated R3 was independent and did say she was in pain. V23 stated she told the nurse (V26/LPN-Licensed Practical Nurse) and they said the hospital didn't send a prescription for the pain medication.On 8/6/25 at 10:59 AM, V25 (CNA) stated she provided care to R3 on her day of admission, and she was hurting that day. When asked what they were doing to treat the pain, V25 stated they were calling the pharmacy.On 8/6/25 at 10:23 AM, V26 (LPN/Licensed Practical Nurse) stated she was the nurse who admitted R3 to the facility. V26 stated she didn't remember what time R3 arrived at the facility. V26 stated she came in towards the end of her 6 am to 6 pm shift. V26 stated she complained of pain and V26 messaged the physician. V26 stated the hospital said they sent prescriptions for R3's pain medications, but R3 didn't have them. V26 stated she messaged R3's physician and he never responded.On 8/6/25 at 9:36 AM, V27 (RN/Registered Nurse) stated she was helping on R3's unit on her day of admission, 7/30/25. V27 stated she and V26 (LPN) were doing R3's admission together. V27 stated she left around 4:30 PM. V27 stated she did the charting and V26 put the medications in the system. V27 stated she could tell R3 was in pain, and she told V26 who was working on the orders. On 8/4/25 at 2:42 PM, V6 (Registered Nurse/RN) stated R3 admitted to the facility on [DATE], and her medications weren't available. V6 stated R3 was hurting, and it was an all-day event getting her pain medication. V6 stated towards the end of her shift (7/31/25), they were able to get in touch with R3's physician (V5), and got a prescription for her Percocet. V6 stated she had another nurse message V5 on their message app first thing that morning, since she didn't have access to the app yet V6 stated V2 (Director of Nurses) got involved with it and V5 gave them the</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>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were available as ordered by the physician for 1 of 1 (R3) residents reviewed for pharmacy services in the sample of 19. Findings Include:R3's facility admission Record, with a print date of 8/4/25, documents R3 was admitted to the facility on [DATE], with diagnoses that include sacroiliitis, surgical aftercare, diabetes, asthma, anemia, restless leg syndrome, Alzheimer's disease, and radiculopathy of lumbar region.R3's Baseline Care Plan, dated 7/30/25, documents R3 is alert with cognitive impairment. This Care Plan documents, family states resident gets confused at times. Under Pain, this Care Plan documents R3 is in pain with no pain level documented.R3's Order Summary Report documents the following physician orders were started on 7/30/25: Aricept 5 milligrams (mg) give 5 mg by mouth at bedtime, Lantus 100 unit/ml (milliliters) inject 30 units subcutaneously at bedtime for diabetes, Lyrica 100 mg give 100 mg at bedtime for pain, ropinirole 2 mg give by mouth at bedtime for Parkinson's, Seroquel 50 mg give one at bedtime for depression, Zocor 40 mg give one tablet at bedtime for prophylaxis, Lamictal 100 mg two times a day for seizures, Pepcid 40 mg give two times a day for gastroesophageal reflux disease and oxycodone -acetaminophen Oral Tablet 5-325 mg give 1 tablet orally every 6 hours as needed for pain.R3's Medication Administration Record, dated 7/1/25 to 7/31/25, documents the following physician orders. Aricept 5 milligrams (mg) give 5 mg by mouth at bedtime, Lantus 100 unit/ml (milliliters) inject 30 units subcutaneously at bedtime for diabetes, Lyrica 100 mg give 100 mg at bedtime for pain, ropinirole 2 mg give by mouth at bedtime for Parkinson's, Seroquel 50 mg give one at bedtime for depression, Zocor 40 mg give one tablet at bedtime for prophylaxis, Lamictal 100 mg two times a day for seizures, Pepcid 40 mg give two times a day for gastroesophageal reflux disease and oxycodone -acetaminophen Oral Tablet 5-325 mg give 1 tablet orally every 6 hours as needed for pain. On 7/30/25 at 8:00 PM, the above listed orders all document a 9 and initials indicating these medications were not administered as ordered. R3's Progress Notes document the following.7/30/25 10:12 AM, report called from (name of regional hospital) .female with hx (history) of DM (diabetes mellitus), stroke, breast cancer, sleep apnea, parkinsons, seizures, RLS (restless leg syndrome), liver failure, depression, GERD (gastroesophageal reflux disease), kidney stones. Resident c/o (complaints of) rt (right) leg pain, rx (prescription) for Percocet is being sent. Has lumbar laminectomy on 7/25 with a pain stimulator present. 7/30/25 2:30 PM, Resident arrived via family personal car. Resident assisted into bed. Resident is A/O (alert and oriented) x (times) 4 at this time, with family at bedside.7/30/25 4:47 PM, Messaged MD (physician) for RX for Percocet as no scripts came with resident. Hospital stated they sent RX with her. Awaiting response. 7/31/25 8:58 AM, Resident c/o pain 8/10. MD notified for PRN (as needed) pain pill Percocet 7.5/325 pm q (every) 6 (hours) signed script.7/31/25 9:53 AM, Tylenol offered for pian. Res (resident) refuses states it won't work. Awaiting response from MD for PRN Percocet script.7/31/25 5:22 PM, Pharmacy contacted for emergency release code for Percocet from cubex. Medication obtained and administered to patient.On 7/31/25 at 2:49 PM, R3 was laying in her bed covered with blankets. R3 stated she arrived at the facility yesterday morning and hasn't had any pain medication since her arrival. R3 stated she didn't get any medications until about an hour ago. R3 stated, Last night was rough, no sleep, just sat here crying in the blanket. When asked why she didn't get her medications including her pain medication, R3 stated they didn't get the order from the doctor and couldn't get it from the pharmacy.On 8/6/25 at 10:37 AM, V23 (Certified Nursing Assistant/CNA) stated she provided care for R3 on her day of admission. V23 stated R3 was independent and did say she was in pain. V23 stated she told the nurse (V26/LPN-Licensed Practical Nurse) and they said the hospital didn't send a prescription for the pain medication.On 8/6/25 at 10:59 AM, V25 (CNA) stated she provided care to R3 on her day of admission, and she was hurting that day. When asked what they were doing to treat the pain, V25 stated they were calling the pharmacy.On 8/6/25 at 10:23 AM, V26 (LPN/Licensed Practical Nurse) stated she was the nurse who admitted R3 to the facility. V26 stated she didn't remember what time R3 arrived at the facility. V26 stated she came in towards the end of her 6 am to 6 pm shift. V26 stated she complained of pain and V26 messaged the physician. V26 stated the hospital said they sent prescriptions for R3's pain medications but R3 didn't have them. V26 stated she messaged R3's physician and he never responded.On 8/6/25 at 9:36 AM, V27 (RN/Registered Nurse) stated she was helping on R3's unit on her day of admission, 7/30/25. 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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>(continued on next page)</p>

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had water available to them in their rooms for 4 of 4 (R1, R2, R6, R7) residents reviewed for hydration in the sample of 19. Findings Include: 1.R2's facility admission Record, with a print date of 08/07/2025, documents R2 was admitted to the facility on [DATE], with diagnoses that include cerebral palsy, acute kidney failure, diabetes, and hypertension.R2's MDS (Minimum Date Set), dated 07/22/2025, documents R2 has a BIMS score of 12, indicating a moderate cognitive deficit. R2's current Care Plan documents a Focus area of, (R2) has potential for nutritional complications r/t (related to) obesity and dietary restrictions secondary to therapeutic diet .(R2) is on an LCS (low concentrate sugars), regular texture diet, with thin liquids. Date Initiated: 04/18/2025. This same Focus area includes the intervention of, Provide, serve diet as ordered .On 7/31/25 at 1:53 PM, R2 was laying in his bed with the bedside table located under the television on the other side of the room at the foot of the bed. R2's pitcher of water with water but no ice in it, was sitting on the table. R2 stated that was his table and his water, and he wouldn't be able to reach it.2. R7's facility admission Record, with a print date of 8/4/25, documents R7 was admitted to the facility on [DATE], with diagnoses that include heart failure, atrial fibrillation, cognitive communication deficit, chronic pain, post-traumatic stress disorder and weakness. R7's MDS, dated [DATE], documents a BIMS score of 15, indicating R7 is cognitively intact.On 7/31/25 at 2:02 PM, R7's pitcher of water was located on his table under his television that was on next to the wall across from the foot of his bed. When asked about the water, R7 stated, It's hot. There isn't any ice. It has been a couple of days since it has been refreshed. R7 stated he got his own ice the other night.3. R6's facility admission Record, with a print date of 8/4/25, documents R6 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction, weakness, diabetes, hypertension, hearing loss, and difficulty walking.R6's MDS, dated [DATE], documents a BIMS score of 12, indicating a moderate cognitive deficit. On 7/31/25 at 2:04 PM, R6 stated this morning they didn't have any ice or water. R6 stated he normally gets it himself in the room down by the nurse's station. R6 stated there is a cart with water on the bottom and a cooler on the top. R6 stated sometimes they don't have any ice.On 8/4/25 at 8:41 AM, R6 had a pitcher sitting on his over the bed table with pink liquid in it. R6 stated he had poured his punch they served with his meal in his water pitcher. R6 stated he wasn't offered ice water yesterday, and normally just gets it himself two or three times a day.4. R1's facility admission Record, with a print date of 8/4/25, documents R1 was admitted to the facility on [DATE], with diagnoses that include right femur fracture, generalized anxiety disorder, muscle weakness, and difficulty walking.R1's MDS (Minimum Data Set), dated 7/27/25, documents a BIMS (Brief Interview for Mental Status) score of 15, indicating R1 is cognitively intact.On 7/31/25 at 2:15 PM, a pitcher for water was sitting on R1's over the bed table filled about halfway with water and no ice. When asked when the staff had last filled her water pitcher, R1 stated, They only do it when I ask them to.On 8/4/25 at 8:51 AM, R1's water pitcher was sitting on her over the bed table with water but no ice in it. R1 stated she doesn't get it filled unless she asks for it. R1 stated the last time she asked for it to be filled was yesterday. R1 stated she normally pours her water from the cups that are served with her meals in her water pitcher.On 8/4/25 at 3:06 PM, V8 (Restorative Aid/CNA -Certified Nursing Assistant) stated she had residents complain to her they weren't getting ice or water, but it had been better the past couple of days. V8 stated they had a hall monitor who wasn't passing ice water the way they should.On 8/4/25 at 4:24 PM, V4 (CNA) stated she didn't understand why the residents didn't have water because the hall monitors passed it, and they were normally good about doing it first thing in the morning. V4 stated she then checks the water around noon to make sure they don't need more.On 8/6/25 at 1:11 PM, V2 (Director of Nurses) stated staff should be passing ice water at the beginning of each shift, with meals, and as needed.The facility was unable to provide this surveyor with a policy regarding ensuring residents have water available in their rooms.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure they had a working call system for 5 of 5 residents (R1, R2, R4, R6, R7) reviewed for call lights in the sample of 19. Findings Include:1.R1's facility admission Record, with a print date of 8/4/25, documents R1 was admitted to the facility on [DATE], with diagnoses that include right femur fracture, generalized anxiety disorder, muscle weakness, and difficulty walking. R1's MDS (Minimum Data Set), dated 7/27/25, documents a BIMS (Brief Interview for Mental Status) score of 15, indicating R1 is cognitively intact. R1's current Care Plan documents a Focus area of, Transferring: (R1) has a self care deficit in transferring r/t (related to) recent fall with R (right) femur fx (fracture), WBAT (weight bearing as tolerated) status to RLE (right lower extremity), and deconditioning. Date Initiated: 07/23/2025. This Focus area includes the intervention of Use adaptive equipment: Standard Walker/Rolling Walker/ Quad Cane/Sliding Board/Gait belt. Date Initiated: 07/23/2025. This same Care Plan documents a Focus area of, (R1) has a R (right) Hip Fracture r/t (related to) a fall at home prior to admission. She had ORIF (Open Reduction Internal Fixation) on 7/19/25 with rod placement. Date Initiated 07/31/2025. This Focus area includes interventions of Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Date Initiated: 07/31/2025.On 07/31/25 at 2:15 PM, R1 was sitting on the edge of her bed with her wheelchair in front of her. R1 stated she needed assistance swinging her legs onto the bed. There was a bell sitting on the over the bed table located on the opposite side of the bed. R1 was not within reach of the bell and stated she couldn't reach it. R1 stated she had been yelling for assistance, and no one had come. R1 stated there was no working call system in her room or in the bathroom. R1 yelled for help at 2:21 PM and stated she had yelled prior to this surveyor entering her room (2:15 PM). R1 stated one time she went to the bathroom and was left sitting on the commode for 30-45 minutes. R1 stated staff would come tell her they were going to assist, leave, and not come back. R1 stated the call system had been down for a while. R1 stated they gave them cheap bells, and no one could hear them, so they gave them cow bells. No staff had responded to R1's yell for assistance, so this surveyor handed her the bell at 2:27 PM. R1 rang the bell and staff responded at 2:28 PM.On 7/31/25 at 2:29 PM, V4 (CNA/Certified Nursing Assistant) stated the call system had been down since she worked on Sunday night (7/27/25). V4 stated she wasn't sure how long they were down prior to her shift. V4 stated they got bells for the residents to ring when they needed assistance, and she takes the bells to the bathrooms with the residents. V4 stated she tried to remind residents who are independent to take their bells with them. V4 stated she can normally hear residents2.R4's facility admission Record, with a print date of 8/6/25, documents R4 was admitted to the facility on [DATE] with diagnoses that include heart failure, dependence on supplemental oxygen, anemia, anxiety, hypertension, and weakness.R4's MDS, dated [DATE], documents a BIMS score of 15, indicating R4 is cognitively intact.R4's current Care Plan documents a Focus area of (R4) has a Functional Self Care Performance Deficit r/t weakness, limited mobility, deconditioning, and decreased strength.Date Initiated: 02/27/2025. This same Focus area includes the following intervention, Encourage (R4) to use bell to call for assistance.On 8/4/25 at 9:30 AM, this surveyor heard a bell ringing and attempted to locate the sound. After entering several rooms, this surveyor entered R4's room. R4 had a small desk top type bell and his call light in his hands. R4 was ringing the desk top bell and pushing his call light. R4 stated, I've been calling for a while, no one has come. I have to use the bathroom. I need the pot. Please help. This surveyor pushed the call light with no response. This surveyor exited the room and found V21 (CNA/Certified Nursing Assistant). V21 entered the room and pushed both call lights in the room and determined neither call light was working. V21 assisted R4 to the commode.3. R6's facility admission Record, with a print date of 8/4/25, documents R6 was admitted to the facility on [DATE], with diagnoses that include cerebral infarction, weakness, diabetes, hypertension, hearing loss, and difficulty walking.R6's MDS, dated [DATE], documents a BIMS score of 12, indicating a moderate cognitive deficit. This same MDS documents R6 requires set up or clean up assistance with showering and toilet hygiene.R6's current Care Plan documents a Focus area of, (R6) has potential for a communication deficit r/t (related to) Hearing impairment. He is hard of hearing in both ears. He is usually able to understand others if they speak loudly. Date Initiated: 05/08/2025. This same Focus area includes interventions of, Ensure/provide a safe environment: Call light in reach.Date Initiated: 05/08/2025.On 7/31/25 at 2:04 PM, R6 was sitting in bed. R6 stated he had a call light but they say they can't answer it. It doesn't seem to work. R6 pressed his call light</p>		