STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145863	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Marion	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 0689 Level of Harm - Minimal harm or potential for 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)

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 0689 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 interview and record review, the facility failed to provide adequate supervision to prevent an elopement for 1 of 3 residents (R1) reviewed for elopement risk in the sample of 15.This past noncompliance occurred from 10/19/2025 to 10/20/25.Findings include:R1's admission record documents an admission date of 9/13/25, with the following diagnoses: unspecified intellectual disabilities, paranoid schizophrenia, anxiety, unspecified, and difficulty in walking.R1's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 13, indicating R1 is cognitively intact.R1's Elopement/Wandering Risk Assessment, dated 8/27/25, documents R1 is at risk for wandering and elopement.R1's Care Plan documents R1 is an elopement risk/wanderer related to impaired safety awareness, reports he is waiting for someone to come get him, frequently sits by exit doors with an initiation date of 9/15/25. Interventions listed include in part; Identify pattern of wandering.Intervene as appropriate.R1's Progress Note, dated 10/16/2025 at 6:03pm, Res (resident) has begun exit seeking stating, 'My brother is supposed to come pick me up. I'm going home today. That's what they told me.' Res has attempted to leave facility and was redirected multiple times; resident continues to bring his personal belongings to front door and sit in lobby chair staring out of the window. Res not combative or irritated, just pleasantly confused and able to be redirected, but this behavior is different from his normal baseline. UA (urinalysis) with culture if indicated order implemented per standing orders and to be obtained upon next void.R1's Progress Note, dated 10/19/25 at 4:47pm, documents, Around 1500 (3:00pm) this nurse noticed res was not in his bedroom or dining room. No door alarms sounding. Elopement drill immediately initiated. All staff checked the entire building inside and outside twice, unable to locate resident. Head count for the entire building completed, unable to locate resident. Attempted to call POA (Power of Attorney) two separate times, going straight to voicemail and voicemail box saying it is full. (local) Police Department called at 1600 (4:00pm), notified cops of missing resident. cops arrived at 4:10pm and took resident information from this nurse. Spoke with cops for roughly 10 minutes, cops stated they would begin attempting to locate res. Cop stated for facility staff to check entire building again. Facility staff searched the entire building and did a head count again. This nurse called POA again at 1625 (4:25pm), POA answered and stated cops had made contact with res. POA stated res is at his brother's house. POA requested to know when cameras show res leaving the facility and how he got out, this nurse informed POA that the facility does not have cameras. POA stated that res is stating that 'his roommates family member that was visiting today was saying hateful things to him' POA requested a meeting with the administrator ASAP, stated it must be this week to discuss. This nurse received a phone call from (local) Police Department who stated res had been located, safe and unharmed and that someone would be bringing him back to facility this evening. This nurse notified Regional Nurse about POA requesting a meeting with administrator, Regional Nurse stated POA could do meeting with the administrator whenever POA would like. This nurse called POA back at 1700 (5:00pm), POA did not answer but called this nurse back at 1710 (5:10pm).This nurse confirmed with POA again that res is at brother's house in (name of city) and that res left facility on his own and would be returning to facility this evening/tonight. POA stated '(R1) is at his brother in laws house which is in 9name of city) and his brother will be bringing him back to the facility later. POA also states he walked to his brother's house from the facility on his own.R1's incident description in the electronic health record tiled Elopement, dated 10/19/25, documents the above Progress Note dated 10/19/25 at 4:47pm. Under Immediate Action Take documents INT (intervention): Resident to have personalized redirection (paint, talk about the Steelers, call brother-in-law) when wandering and room change to make resident more comfortable. RCA (Root Cause Analysis): Resident states he was upset about his roommate's family being mean to him so he walked to his brother in laws house.Several attempts to interview R1 were made and unsuccessful throughout the survey. R1 did not respond to questions asked. On 10/30/25 at 1:45pm, V3 (Regional Director of Clinical Services) stated the was aware R1 completed a Brief Interview for Mental Status (BIMS) and staff were able to get a score of 13, but that is not typical for R1. V3 stated R1 usually does not say too much, but due to several factors, including mental health diagnoses, it all depends on his level of comfort with the person engaging in conversation with. V3 stated on 10/1925, R1's family reported his roommate's family was being mean to R1. V3 stated R1 has schizophrenia and previously lived at a sister facility. V3 stated often R1 would have to be moved to a room alone because he thought his roommate was out to get him. V3 stated R1 did not wear a electronic monitoring device prior to