

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 12/09/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600</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 interview and record review, the facility failed to ensure a resident was free from intimidation/verbal abuse for 1 (R11) of 3 residents reviewed for abuse in the sample of 13. Findings include: R11's admission Record documents an admission date of 10/21/25, and included diagnoses of Osteomyelitis, Type 2 Diabetes Mellitus with skin complications, Traumatic Amputation of Right Great Toe, Hyperlipidemia, Bipolar Disorder, and Hypertension. R11's Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R11's cognition is intact. A facility document titled Employee Action Form with V11's (Former Dietary Aide/Cook) name on it documents her last day worked as 11/17/25. Under Employee Action/Discipline is a box for selected for Termination with a Termination Date written in as 11/18/25. The offense listed documents, Insubordination, including refusal to do job assignment. A date and time of incident is listed as 11/17/25 at 6:30pm and location listed was the Kitchen. The description documents, Resident asked cook for a grilled cheese and (name of V11) told resident, I am not making any more f***ing grilled cheese. RN (Registered Nurse name) asked (V11) for sandwich as well and (V11) refused. V7's (Former Dietary Manager) signature was listed under Supervisor Signature with a date of 11/18/25 and a box marked Not Rehire-able was checked. Another Employee Action Form for V11 was marked Termination with an offense of Inappropriate conduct towards a resident with an incident date of 11/17/25 at 8pm and documented, (V11) was asked by a resident to make her a grilled cheese, and (V11) refused saying 'you got a normal f***ing tray, I am not making any more grilled cheese.' This language towards a resident is not acceptable and is subject to termination. This document is signed by V7 and dated 11/18/25. A third Employee Action Form for V11 was marked Termination with an offense of sleeping on duty with an incident date of 11/17/25 at 9pm in the kitchen. An untitled document appearing to be R11's written statement regarding the above incident documents, Resident asked cook, (V11) for a grilled cheese sandwich before dinner service began at 5:30PM. Cook, (V11) ignored resident's request throughout service and gave resident a normal tray without the grilled cheese. When resident approached the kitchen, (V11) said 'You got a normal f***ing tray, I am not making any more f***ing grilled cheese' and walked away. Resident asked once again for a sandwich and cook ignored resident's request. Resident immediately notified their nurse, and their nurse immediately notified Dietary Manager and Administrator of the incident. The statement was signed by R11 and dated 11/17/25. An untitled document appearing to be V19's (Licensed Practical Nurse/LPN) statement documented, resident (R11's initials) came up to this writer and reported that head cook was rude/disrespectful towards her. When asked what happened res (resident) stated me and my roommate had ordered burger and grilled cheese instead of our tray and I went to check in and see if it was ready and was told 'you guys got a tray, and you don't get anything else. I guess I'll make it but this is the last f***ing grilled cheese I make.' This nurse also noted that two other residents had not received their trays. Went to talk to kitchen staff about issue. [NAME] had a very bad attitude stating that she didn't know who I was talking about and that they had been done serving food for 45 minutes at this point and she didn't understand why things are being ordered now. This is not the 1st time these issues have been occurring with the same staff member. Kitchen Supervisor and Admin (Administrator) made aware of this. Staff member was sent home. This nurse was a witness along with floor hall monitor. This statement is signed by V19 (LPN) and dated 11/17/25. Another untitled document appearing to be V22's handwritten statement and dated November 17, 2025 documents, (V22) went to the kitchen to remind them (R2) had already asked for a hamburger. (V11) then said she has made all she is making and went outside. (R11) then asked about her food. (V22) went into the kitchen and made (R11) .and R2's sandwiches. while (V11) was in (V7's) office asleep in the chair. This statement is signed by V22. On 11/24/2025 at 10:39AM, V7 (Former Dietary Manager) stated he was aware of the incident that occurred on 11/17/25 regarding V11 and R11. V7 stated he received a call from a nurse reporting to him that one of his staff members (V11) cursed out R11 and refused to fix R11 a grilled cheese. V7 stated he notified V1 (Administrator) immediately and was directed by V1 to go to the facility and get statements and send V11 home. V7 stated he came to the facility and interviewed R11 and V11 and got statements from staff that heard the incident. V7 stated he sent V11 home. V7 stated he slid the statements under V1's door as he was told. V7 stated the next day he and V1 discussed the situation and V7 stated he wanted to fire V11 for verbal abuse to a resident and V1 stated to him 'Don't fire (V11) for abuse because I will have to report the abuse to Public Health, and I don't want</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</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 interview and record review, the facility failed to report an allegation of verbal abuse to the State Agency and local law enforcement within 24 hours for 1 (R11) of 3 residents reviewed for reporting alleged violations in the sample of 13. Findings include: R11's admission Record documents an admission date of 10/21/25, and included diagnoses of Osteomyelitis, Type 2 Diabetes Mellitus with skin complications, Traumatic Amputation of Right Great Toe, Hyperlipidemia, Bipolar Disorder, and Hypertension. R11's Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R11's cognition is intact. A facility document titled Employee Action Form with V11's (Former Dietary Aide/Cook) name on it documents her last day worked as 11/17/25. Under Employee Action/Discipline is a box for selected for Termination with a Termination Date written in as 11/18/25. The offense listed documents, Insubordination, including refusal to do job assignment. A date and time of incident is listed as 11/17/25 at 6:30pm and location listed was the Kitchen. The description documents, Resident asked cook for a grilled cheese and (name of V11) told resident I am not making any more f***ing grilled cheese. RN (Registered Nurse name) asked (V11) for sandwich as well and (V11) refused. V7's (Former Dietary Manager) signature was listed under Supervisor Signature with a date of 11/18/25 and a box marked Not Rehire-able was checked. Another Employee Action Form for V11 was marked Termination with an offense of Inappropriate conduct towards a resident, with an incident date of 11/17/25 at 8pm, and documented, (V11) was asked by a resident to make her a grilled cheese, and (V11) refused saying 'you got a normal f***ing tray, I am not making any more grilled cheese.' This language towards a resident is not acceptable and is subject to termination. This document is signed by V7 and dated 11/18/25. A third Employee Action Form for V11 was marked Termination with an offense of sleeping on duty with an incident date of 11/17/25 at 9pm in the kitchen. On 11/24/2025 at 10:39AM, V7 (Former Dietary Manager) stated he was aware of the incident that occurred on 11/17/25 regarding V11 and R11. V7 stated he received a call from a nurse reporting to him that one of his staff members (V11) cursed out R11 and refused to fix R11 a grilled cheese. V7 stated he notified V1 (Administrator) immediately and was directed by V1 to go to the facility and get statements and send V11 home. V7 stated he came to the facility and interviewed R11 and V11 and got statements from staff that heard the incident. V7 stated he sent V11 home. V7 stated he slid the statements under V1's door as he was told. V7 stated the next day he and V1 discussed the situation and V7 stated he wanted to fire V11 for verbal abuse to a resident and V1 stated to him, Don't fire V11 for abuse because I will have to report the abuse to Public Health, and I don't want public health in my building over abuse. V7 stated this statement upset him because this was a situation of verbal abuse and should be treated as such. V7 stated he wrote up termination documents and added a reason was for V11 sleeping while at work because that had happened as well. V7 stated after this was all taken care of that day, he then quit and left the facility because as a manager, he didn't feel like he could handle the situation of abuse correctly and the way it should have been handled. On 11/26/2025 at 4:41PM, V19 (Licensed Practical Nurse/LPN) stated she was one of the nurses working on 11/17/2025 when the incident occurred with V11 and R11. V19 stated she was passing medications when R11 approached her and reported she had ordered a grilled cheese and went to the kitchen to get it and V11 cursed at her and refused to make the grilled cheese. V19 stated she reported this to V7 and V7 called V1 (Administrator). V19 stated V7 came to the facility and sent V11 home for verbal abuse to a resident. V19 stated she talked to V1 as well and V1 informed her V7 would be coming to the facility to get statements and V1 would review in the morning. V19 said V1 stated V7 was coming to send V11 home because this was verbal abuse. V19 stated she filled out a report of what happened and turned it in to V7. On 11/24/2025 at 11:00AM, V20 (Administrator at Sister Facility) was covering and present in the facility due to V1 (Administrator) not working. V20 was asked for the facility's reportable abuse incidents, and a report on the incident from 11/17/25 regarding V11 and R11 was not present. V20 checked and stated there were no reports for that date or any regarding V11 and R11. V20 and V6 (Regional Clinical Director) were presented with the statements that were retrieved from V11's personnel file. V6 and V20 reviewed the documents and V20 stated she would report this immediately to the State Agency and start an investigation. On 11/24/2025 at 1:04PM, V1 returned a call to this surveyor and was asked if she reported the incident of verbal abuse that occurred on 11/17/2025 between V11 and R11. V1 stated, No, I didn't report it because I felt it was more like a customer service issue. V1 was asked if she was the Abuse Coordinator and V1</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</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 interviews and record review, the facility failed to complete a thorough investigation in response to an allegation of staff to resident verbal abuse for 1 (R11) of 3 residents reviewed for abuse in the sample of 13. Findings include:R11's admission Record documents an admission date of 10/21/25, and included diagnoses of Osteomyelitis, Type 2 Diabetes Mellitus with skin complications, Traumatic Amputation of Right Great Toe, Hyperlipidemia, Bipolar Disorder, and Hypertension.R11's Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R11's cognition is intact. A facility document titled Employee Action Form with V11's (Former Dietary Aide/Cook) name on it documents her last day worked as 11/17/25. 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When resident approached the kitchen, (V11) said 'You got a normal f***ing tray, I am not making any more f***ing grilled cheese' and walked away. Resident asked once again for a sandwich and cook ignored resident's request. Resident immediately notified their nurse, and their nurse immediately notified Dietary Manager and Administrator of the incident. The statement was signed by R11 and dated 11/17/25. An untitled document appearing to be V19's (Licensed Practical Nurse/LPN) statement documented, resident (R11's initials) came up to this writer and reported that head cook was rude/disrespectful towards her. When asked what happened res (resident) stated 'me and my roommate had ordered burger and grilled cheese instead of our tray and I went to check in and see if it was ready and was told 'you guys got a tray, and you don't get anything else. I guess I'll make it but this is the last f***ing grilled cheese I make.' This nurse also noted that two other residents had not received their trays. Went to talk to kitchen staff about issue. [NAME] had a very bad attitude stating that she didn't know who I was talking about and that they had been done serving food for 45 minutes at this point and she didn't understand why things are being ordered now. This is not the 1st time these issues have been occurring with the same staff member. Kitchen Supervisor and Admin (Administrator) made aware of this. Staff member was sent home. This nurse was a witness along with floor hall monitor. This statement is signed by V19 (LPN) and dated 11/17/25.Another untitled document appearing to be V22's handwritten statement, and dated November 17, 2025, documents, (V22) went to the kitchen to remind them (R2) had already asked for a hamburger. (V11) then said she has made all she is making and went outside. (R11) then asked about her food. (V22) went into the kitchen and made (R11) .and (R2's) sandwiches.while (V11) was in (V7's) office asleep in the chair. This statement is signed by V22. On 11/24/25 at 10:39AM, V7 (Former Dietary Manager) stated he was aware of the incident that occurred on 11/17/25 regarding V11 and R11. V7 stated he received a call from a nurse reporting to him that one of his staff members (V11) cursed out R11 and refused to fix R11 a grilled cheese. V7 stated he notified V1 (Administrator) immediately and was directed by V1 to go to the facility and get statements and send V11 home. V7 stated he came to the facility and interviewed R11 and V11 and got statements from staff that heard the incident. V7 stated he sent V11 home. V7 stated he slid the statements under V1's door as he was told. 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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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<p>F 0677</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 timely incontinence care and repositioning services were provided for 3 (R4, R5, and R10) of 5 dependent residents reviewed for Activities of Daily Living (ADL) care in the sample of 13. Findings include: 1. R4's admission Record documents an admission date of 5/11/22, and included diagnoses of Fracture of part of Neck of Right Femur, Type 2 Diabetes Mellitus, Unspecified Dementia, Convulsions, Anxiety Disorder, and Cognition Communication Deficit. R4's MDS (Minimum Data Set), dated 10/7/25, documented a BIMS (Brief Interview for Mental Status) score of 3, indicating R4 has severe cognition impairment. Under Functional Abilities and Goals, the MDS documents R4 is dependent for eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. 2. R5's admission Record documented an admission date of 12/20/21, and included diagnoses of Chronic Obstructive Pulmonary Disease, Unspecified Protein-Calorie Malnutrition, Osteoporosis, Malignant Neoplasm of Upper Lobe, Right Bronchus or Lung, Hypertension, Hypothyroidism Anemia, Major Depressive Disorder, Anxiety, Drug Induced Dyskinesia, Scoliosis, and Cognition Communication Deficit. R5's MDS, dated [DATE], documented a BIMS score of 12, indicating moderate cognitive impairment. Under Functional Abilities and Goals, the MDS documents R5 requires supervision or touching assistance for eating, and R5 is dependent on staff for oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on and taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. On 11/21/25 from 4:50PM to 7:51PM, continuous observation was made of R4 and R5 in the big dining room while waiting to be served the supper meal. R4 was sitting in a recliner chair at a table in the dining room along with R5, who was sitting in the reclined position of a reclining wheelchair. During this time, R4 and R5 were not assisted with repositioning nor were they toileted or provided incontinence care. On 11/21/25 at 7:51PM, V3 (Assistant Director of Nursing/ADON) and V6 (Regional Clinical Director) were present and were asked how often residents are to be repositioned and checked for incontinence. V6 stated every 2 hours. 3. R10's admission Record documented an admission date of 12/22/23, and included diagnoses of Chronic Kidney Disease, Acute Kidney Failure, Unspecified Dementia, Failure to Thrive, Hypertension, Disorder of Kidney and Ureter, Weakness, and Difficulty Walking. R10's MDS, dated [DATE], documented a BIMS score of 11, indicating R10 has moderate cognitive impairment. Under Functional Abilities and Goals, the MDS documents R10 is dependent for eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on and taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting, sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfers. Under Bowel and Bladder, the MDS documents R10 is always incontinent of bowel and bladder. On 11/24/25, R10 was observed throughout the day beginning at 8:00AM, at various frequent intervals being up in her wheelchair. At 3:00PM, R10 was up in her wheelchair with a sling under her in the wheelchair. On 11/24/25 at 3:10PM, V17 (Certified Nurse Aide/CNA) stated he was taking care of R10 today. V17 was asked if R10 had been laid down or changed throughout the day, and V17 stated he has not laid R10 down or changed her since he got here at 10:00AM. V17 stated he did push R10 down the hall around 10:00AM-10:30AM, but that was all. On 11/24/25 At 3:15PM, R10 was alert and oriented and was asked if she had been up in her wheelchair all day. R10 stated, Yes they got me up for breakfast this morning and I haven't been changed or checked since then. R10 stated, This is normal for the day. They will lay me down before supper and I will eat supper in bed. R10 stated she is incontinent of bowel and bladder. R10 was asked if she was wet and R10 stated, Well yes, I have not been changed all day. On 11/24/25 at 3:45PM, V9 (Certified Nursing Assistant/CNA) stated she was the other CNA working R10's hall for the dayshift and she was also taking care of R10. V9 stated she got R10 up for breakfast in the morning. V9 was asked if she had changed or repositioned R10 throughout the day and V9 stated, No I haven't. V9 stated they were waiting on the mechanical lift to transfer her. V9 was unsure of the exact time she got R10 up for breakfast. On 11/24/25 at 11:28 AM, V15 (CNA) stated there are usually plenty of CNAs to provide good care to the residents. V15 stated she feels like the staff have plenty of time to take good care of the residents. V15 stated she normally works the 200 hall, but she is familiar with R4, R5, and R10, and stated all 3 are incontinent of bowel and bladder. V15 stated all three require assistance with turning and</p>		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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<p>F 0686</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 interventions were developed and implemented for the prevention of pressure ulcers for 1 (R5) of 3 residents reviewed for pressure ulcers in the sample of 13. Findings include: R5's admission Record documented an admission date of 12/20/2021, and included diagnoses of Chronic Obstructive Pulmonary Disease, Unspecified Protein-Calorie Malnutrition, Osteoporosis, Malignant Neoplasm of Upper Lobe, Right Bronchus or Lung, Hypertension, Hypothyroidism Anemia, Major Depressive Disorder, Anxiety, Drug Induced Dyskinesia, Scoliosis, and Cognitive Communication Deficit. R5's Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The MDS Section GG (Functional Abilities and Goals) documented R5 is dependent on staff for rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Section M documents R5 is at risk for pressure ulcer development. Under Skin and Ulcer/Injury Treatments Pressure reducing device for chair and Pressure reducing device for bed are marked. R5's Care Plan documents R5 is at risk for pressure ulcer development related to impaired mobility, decreased cognition, decreased strength, incontinent of bowel and bladder, and fragile skin (date initiated 9/16/2025). Corresponding interventions included: follow facility policies/protocols for prevention/treatment of skin breakdown dated 9/12/2025, skin checks as scheduled 9/12/2025, (Name of physician) wound specialist to evaluate and treat as indicated, assess/record/monitor wound healing weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing process. Report improvements and declines to MD 9/12/2025. Other interventions include monitoring of nutrition, labs, medications, and monitor/document/report changes to the MD as needed for changes in skin status all dated 9/12/2025. R5's Care Plan did not document interventions including the use of pressure relieving devices for R5's chair or bed. R5's Braden's Assessments, dated 9/11/2025 and 11/5/2025, documented R5 was low risk for skin issues with a score of 15. R5's Weekly skin assessments for R5 dated 10/24/25, 10/31/25 and 11/14/2025 document no skin issues with no redness. On 11/21/2025 from 4:50PM to 7:51PM, continuous observation was made of R5. R5 was in the dining room in a reclining wheelchair with no repositioning provided to R5 during that time. V6 (Regional Clinical Director) and V3 (Assistant Director of Nursing/ADON) were informed that continuous monitoring had occurred for repositioning on R5, and she had not been repositioned for 3 consecutive hours. V3 and V6 were asked how often residents are to be repositioned and checked for incontinence and V6 stated it is every 2 hours. V6 was asked if R5's chair had a pressure relieving cushion, and V6 checked and stated none was noted. V6 instructed staff to place a pressure relieving cushion under resident when she is in her chair. On 11/23/2025 at 12:20PM, R5 was noted to be in the dining room waiting on lunch. R5 was sitting in her reclining wheelchair in the reclined position. R5 was noted to have pillows on each side for positioning. R5 still did not have a pressure relieving cushion under her in the reclining wheelchair. V6 was present and stated, Well (R5) does need one and I will make sure she gets one in her chair. On 11/23/2025 at 4:20PM, V8 and V9 (both Certified Nurse Assistants/CNA's) provided peri care to R5. R5 was noted to have a red coccyx and surrounding area as well as red areas to her ankle bones. The red area to R5's coccyx was slightly blanchable at this time and the red area to ankle bones was completely blanchable. V6 was present for the observation and instructed the nurse to get orders for boots and orders for cream (treatment) for R5's coccyx and surrounding areas. R5 was on a standard mattress at this time. On 11/24/2025 at 11:48AM, V17 (CNA) stated he normally works everywhere in the building, but he often takes care of R5. V17 stated all residents should have cushions in their chair, but he does know that since he has worked here, R5 has never had a cushion in her chair, and he is not sure why. On 11/25/2025 at 8:48AM, V12 (CNA/Supervisor) stated all the residents get and need a pressure relieving cushion unless they refuse them. On 11/25/2025 at 9:00AM, V13 (CNA) stated they try to keep pressure relieving cushions in all the residents' chairs. V13 stated, We are expected to change and reposition residents every 2 hours and we really try to make sure that happens. Meals have been running late recently, but we still should make sure the residents are repositioned. On 11/25/2025 at 9:30AM, V14 (Licensed Practical Nurse/LPN) stated he expects the staff to turn and position residents every 2 hours. V14 was asked what happens when residents have to sit longer than 2 hours in the dining room waiting on tray and V14 stated, I don't have an answer. On 11/25/2025 at 9:53AM, V2 (Director of Nursing/DON) stated she</p>		

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 12/09/2025
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.

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>(continued on next page)</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review, the facility failed to ensure meals were served in a timely manner. This failure has the potential to affect all 112 residents residing in the facility. Findings Include: On 11/21/25 at 2:19PM, R1 was alert and oriented and was asked how his meals were and if they were they served on time. R1 stated, It seems like we have a lot of reruns on the meals, but I think they try to follow the menu the best they can. R1 stated the meals are sometimes late and he wasn't sure why. When asked if the food and time the meals were served was ok, R1 stated, Well, that is debatable. On 11/21/25 at 3:30PM, V5 (Head Cook) stated there was a no call/no show for the shift so they are running way behind on everything. V5 said they usually have all the dishes from lunch done by now. V5 stated they are short staffed right now and are sometimes late with the meals. On 11/21/25 at 4:50PM, several residents were observed to be sitting in the big dining room awaiting the supper meal to be served. R4 was sitting in a recliner chair at a table in the dining room along with R5, who was sitting in the reclined position of a reclining wheelchair. At 5:15PM, several department heads and staff members gathered in the big dining room to help serve the supper meal. There were 14 staff members lined up waiting on trays to start to come out of the kitchen. R1 was sitting in the dining room waiting for supper and stated to this surveyor, Wow, I have never seen so many staff members here to help with any meals; I guess it is because you are here watching. The first tray went out at 5:37PM and was served to the 200 Hall. The hall trays were going out individually by staff, one at a time. The trays for the 100 hall started going out at 5:42PM. At 6:02PM, trays were being walked to the 300 hall. At 6:05PM, R6 left the big dining room and returned with a big bag of chips and was sharing them with R7. R6 stated, We are really hungry, so we have to eat chips for now. A cart with several trays went to the small dining room at 6:16PM. The first tray to be served in the big dining room was at 6:17PM. On 11/21/25 at 7:15PM, R1 received a tray containing fish, green beans, au gratin potatoes, and pudding. R1 stated, This is the way it normally goes lately, with the time of getting supper. On 11/21/25, R5 received a tray at 7:17PM. On 11/21/25 at 7:18PM, R8 was alert and oriented, sitting at the table in the big dining room with no tray, and was dressed with a jacket on and purse sitting on the table. This surveyor asked R8 if she was a visitor and R8 stated, No, I live here and I guess I won't get a tray again, so I am just going back to my room without supper again. This surveyor asked R8 to stay so she could get a tray. V6 (Regional Clinical Director) was sitting at the next table assisting residents and was notified R8 did not get a tray. V6 went to the kitchen door immediately and brought back R8 a tray. While V6 was at the door waiting on R8's tray, a CNA came up and told V6 that R9 did not get a tray either, and R9 needed a tray so she could get fed. V6 stated, I thought I saw that tray go out, but we will get her one right now. The last supper trays were served to R8 and R9 at approximately 7:20PM. On 11/23/2025 at 12:30PM, R1 was sitting in the big dining room waiting on his lunch tray. The first tray came out of the kitchen at 1:00PM. The hall trays were the first trays to go out. The trays in the big dining room were not started until 1:27PM with last tray out at 1:53PM. R1 did not receive a tray until 1:38PM. On 11/24/25 at 11:48AM, V17 (Certified Nurse Assistant/CNA) stated he was working 11/21/25 when the supper meal was very late. V17 stated that is not unusual for meals to be late. On 11/25/25 at 8:48AM, V12 (CNA/Supervisor) stated meals do run late at times. On 11/25/25 at 9:00AM, V13 (CNA) stated meals have been running late recently. On 11/25/25 at 9:30AM, V14 (Licensed Practical Nurse/LPN) stated there have been times that the trays were running late, and he was worried about the diabetics that get insulin, but so far, he has not had any issues. On 11/25/25 at 9:27AM, V18 (Registered Nurse/RN) stated she has noticed meals running late recently and she watches her diabetic residents closely, and does not give their insulin until the meal is ready to be served. A facility provided document titled Mealtimes documents Breakfast at 8:30AM, Lunch at 12:30PM, and Supper at 5:30PM.</p>		