

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 01/30/2026
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to answer call lights timely for 6 (R2, R10, R11, R12, R13, R14) of 6 residents reviewed for call lights in the sample of 14. Findings include:R2's admission record, dated 1/28/26, documents an admission date of 8/25/25. R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a Brief Interview for Mental Status (BIMS) score of 13, indicating R2 is cognitively intact.On 1/27/26 at 12:03 P.M., R2 stated upon his arrival back from his hospital admission, they moved R2 into a new room. R2 stated his sheets and mattress were wet, so his daughter initiated the call light to have someone come and change the sheets and dry the mattress. R2 stated he could not remember the exact amount of time it took for staff to answer the call light, but it took well over 15 minutes. On 1/27/26 at 2:09 P.M., V24, Family Member, stated when her father, R2, had been moved into a new room from his return from a hospital admission a couple of weeks ago, she noticed the sheets and the mattress of his bed were wet. V24 stated she then initiated the call light system to get fresh sheets. V24 stated to determine how long it took staff to answer the call light she timed them according to her phone's watch. V24 stated she hit the call light button at 8:20 P.M., and the staff did not answer the call light until 9:00 P.M. V24 stated she does remember the day; it was January 13th, a Tuesday, when this happened. V24 stated she tried to get hold of the Administrator to report her concern about call light wait times but was never successful in reaching her. V24 stated she played phone tag with the Administrator a few times, and then eventually stopped trying.R14's resident grievance form, dated 11/13/25, documents resident feels like it takes a long time for staff to answer call lights on night shift.R12's resident grievance form, dated 11/18/25, documents resident feels like Certified Nurse Aides are not answering her call light in an appropriate amount of time.R13's resident grievance form, dated 12/1/25, documents resident stated nursing staff were not timely in answering his call light .R10's resident grievance form, dated 1/11/26, documents, resident stated his call light takes over 30 minutes to be answered and when someone comes, they turn it off and never come back to address the issue.R11's resident grievance form, dated 1/21/26, documents residents Power of Attorney called the facility complaining his mother had soiled herself because her call light had not been answered in 4 hours. On 1/29/26 at 9:13 A.M., V2, Regional Director of Clinical Operations/Acting Director of Nurses, stated he has not received any recent complaints of call lights being answered timely. V2 stated, I did look back at the grievances you talked about, and it looked like they were addressed and resolved. V2 stated he thought call lights should be answered as quickly as possible. V2 stated when asked about how long it should take to answer a call light, he stated he didn't want to give a time limit because it would depend on what's going on down the hall, but would consider fifteen minutes to be an appropriate maximum amount of time to answer a call light. V2 stated the facility does not have a call light policy.On 1/29/26 at 9:36 A.M., V1 stated she has not been made aware of complaints of call lights being answered timely. V1</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>stated she believes call lights should be answered as quickly as possible depending on what's going on down the hall. V1 stated she did not want to give a maximum time limit for appropriate time limit to answer a call light because it would all depend on what was going on and what was the situation that would take precedence. V1 stated the facility doesn't have a call light policy.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to clean a newly admitted resident's room after one resident was moved out and he was moved in for 1 (R2) of 3 residents reviewed for environment in a sample of 9. Findings include:R2's admission record, dated 1/28/26, documents an admission date of 8/25/25. R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a Brief Interview for Mental Status (BIMS) score of 13, indicating R2 is cognitively intact.On 1/27/26 at 12:03 P.M., R2 stated upon his return from a hospitalization in the middle of January, he was moved into a different room than the one he originally had because he was on isolation for influenza or something else (can't remember). R2 stated the beds in the new room were dirty and didn't appear to have been cleaned prior to the former occupant being moved out and himself moving in. On 1/27/26 at 2:09 P.M., V24, Family Member, stated the new room the facility placed her father in did not appear to have been cleaned or sanitized upon last resident's exit. V24 stated there was dirt on the floor, what appeared to be used oxygen tubing laying in the chair, there was a cupcake in a container on the overbed table, and the empty bed next to R2 had what appeared to be food crumbs on it. V24 stated when she entered the private bathroom for this room, it appeared the toilet had not been cleaned prior to the last resident's exit. V24 stated there were brown stains like feces on the porcelain of the bowl of the toilet.On 1/29/26 at 8:18 A.M., V5, Housekeeping Supervisor, stated the housekeepers do have a daily schedule for cleaning. V5 stated every resident room should be cleaned every day. V5 stated cleaning in the resident's room includes wiping down all high touch surface areas with sanitizer wipe or spray, sweeping, mopping of the floors, emptying trash cans, and cleaning private bathroom lavatories and toilets if they have one every day. V5 stated mattresses and bed frames are cleaned twice per week on resident's shower day when not in the resident is not in the bed. When asked about the room reportedly not cleaned before R2's placement in the room, V5 stated there was a miscommunication. V5 stated the housekeeper who was supposed to be responsible for cleaning the room thought she had more time to get it cleaned and went ahead and went to lunch. By the time the housekeeper got back and headed to clean the room, the resident, R2, had already been placed in the room. V5 stated they (housekeeping staff) thought they had more time to get the room clean, but the resident had come back sooner than expected from the hospital. V5 stated she thought the room had already been cleaned, but it had not between one resident moving out and the other R2 moving in. V5 stated the next day, the 14th, she went down and deep cleaned the room herself. V5 stated the room should have been cleaned prior to the resident, R2 being placed in the room.On 1/29/26 at 9:13 A.M., V2, Regional Director of Clinical Services/ Acting Director of Nurses, stated he had not received any complaints regarding facility cleanliness over the last month or so. V2 stated he had heard of a complaint about a room not being cleaned while he was on vacation the last part of December, first part of January, but didn't know the details of it. V2 stated he only heard about the complaint in passing. V2 stated he had not heard anything a room not being cleaned prior to this investigation but stated it should have been cleaned prior to the resident, R2, being placed in it. V2 stated he feels the facility should be kept very clean due to risk of transmitting infections and possible contamination. V2 stated the facility has been short on housekeeping staff in the past and have offered overtime to Certified Nursing Assistants to do housekeeping duties to make sure everything stays clean. When asked about rooms being cleaned daily, V2 stated he would expect the trash to be emptied, the floors swept and mopped , high touch surface areas wiped down with sanitizing wipes or spray, and the bathrooms cleaned.On 1/26/26 at 9:36 A.M., V1, Administrator, stated she has not</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>recently received any complaints of the facility being dirty in general. V1 stated resident rooms should be cleaned daily including high touch surface areas wiped down with sanitizing wipes or spray and the bathrooms cleaned. V1 stated there was a complaint about the room that R2 was placed in upon his return from the hospital not being cleaned prior to him being placed in it. V1 stated, We got report that (R2) was coming back on isolation and that is the room we use for isolation and overflow if we have it. There was a miscommunication and one person thought another person had cleaned the room when actually no one had cleaned it prior to (R2's) entrance. It was an honest mistake. There should have been better communication between housekeeping staff. An undated Deep Cleaning a Room checklist documents the following to be done during the deep cleaning of a room. Take down privacy curtains, strip the beds, wipe down the mattress front and back, wipe down the bed frame, wipe off the control panel, wipe off the nightstands inside and out, wipe off the window seal, wipe down the over the bed table top to bottom, move the nightstands and clean behind them, move the bed and clean where it was sitting, wipe down the walls, move anything else that can be moved and clean where it was sitting, if the room has a bathroom deep clean it, wipe the trash cans inside and out, clean the A/C(air conditioner) (filter and vents), put privacy curtains back up, make the beds, put everything back where it goes.</p>