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	04/08/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to secure medications at the bedside for 1 (R22) of 3 residents reviewed for medications secured at the bedside in the sample of 29.Findings include:On 4/2/26 at 9:58 AM, R22 was sleeping soundly in her bed. R22 responded to her name with a moan/grunt but was not easily awakened. R22 had a medicine cup sitting on her overbed table containing 7-8 tablets of unknown medications. R22 never wakened while this surveyor was in the room.On 4/2/26 at 12:02 PM, R22 who was alert to person, place, and time, stated it was her fault her medications were left on her overbed table. R22 stated the nurse had brought them into her when she was awake, but she fell back to sleep before taking the medication. This surveyor did observe 1 unidentified pill left in her medication cup. R22 stated she was going to take the pill in just a minute. On 4/2/26 at 4:37 PM, V28 (Licensed Practical Nurse/LPN) verified he was the nurse who was supposed to have administered R22's medications. V28 stated it was not safe or appropriate for him to leave R22's medications at bedside and not verifying the medications were administered before leaving the room. V28 stated he should have made sure medications were administered before leaving R22's room.On 4/7/26 at 2:53 PM, V2 (Director of Nurses) stated V28 should not have left R22's medications at bedside without first making sure R22 had been administered the medications. V2 stated one of the main reasons for this is for safety purposes to make sure another demented resident doesn't wander into the room and swallow the medications, or the resident who they are prescribed for doesn't horde them up and take them all at once.On 4/7/26 at 3:25 PM, V1 (Administrator) stated medications should not be left at the resident's bedside at all. V1 stated the main reason for not doing this is because of safety. V1 stated demented residents may wander into a room and swallow the medications by mistake, or if the resident could possibly horde the medications up and take too many at the same time.Facility's medication administration policy, with a revision date of December 2012, documents, Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The individual administering medications must verify the resident's identity before giving the resident his/her medications. Medications cannot be prepared for administration until the resident is present and ready to take the medication.

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

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	04/08/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on interview and observation, the facility failed to provide access to drinking water at the bedside for 4 (R18, R19, R20, R21) of 5 residents reviewed for access to drinking water in a sample of 29. On 3/31/26 at 2:28 PM, there were no water pitchers for R18 and R19 on or near their overbed tables in their room. There were empty cups sitting on the overbed tables of both R18 and R19 with only drops of clear liquid in the bottom.On 3/31/26 at 2:33 PM, there were no water pitchers or cups for R20 and R21 on or near their overbed tables in their room.On 4/1/26 at 8:50 AM, there were no water pitchers for R18 and R19 on or near their overbed tables in their room. There were also no empty or full cups of liquid on or near the overbed table of R18 and R19.On 4/1/26 at 8:55 AM, there were no water pitchers or cups on or near the overbed tables in the room of R20 and R21.On 4/1/26 at 245 PM, V4 (Certified Nurse Aide/CAN) stated all residents should have access to drinking water at their bedside unless they are on a fluid restriction or on thickened liquids.On 4/1/26 at 3:40 PM, V12 (CNA) stated all residents should have access to drinking water at their bedside unless they are on a fluid restriction.On 4/2/26 at 1:46 PM, V25 (CNA) stated all residents should have access to drinking water at their bedside.On 4/6/26 at 9:12 AM, V21 (CNA) stated all residents should have access to water at bedside unless they have some sort of dietary restriction, like thickened liquids. V21 stated for those residents on dietary restrictions, she tries to offer them drinks frequently to make sure they get enough fluid intake.On 4/6/26 at 9:56 AM, V22 (CNA) stated she could not think of any resident that is not supposed to have access to drinking water in their room.On 4/6/26 at 1:51PM, there were no water pitchers or drinking cups at bedside in the rooms of R18-R21.On 4/6/26 at 1:51 PM, V26 and V27, both CNAs working the hall, were asked if there was any fluid restriction or reason R18, R19, R20 and R21 had no water pitchers or drinking cups at their bedside. V26 and V27 could give no reasons why the above residents had no water pitcher or drinking cup at their bedside. V26 and V27 both stated the above residents were not on any type of fluid restriction or thickened liquids.On 4/6/26 at 2:01PM, V2 (Director of Nurses) visited the rooms R18, R19, R20 and R21. At that time R18, R19, R20 and R21 had no water pitchers or drinking cups at their bedside. V2 stated he will check why they don't have any.On 4/6/26 at 2:17 PM, V2 stated there was no reason the above residents shouldn't have had water at the bedside. V2 stated water pitchers with ice water have been provided to the above residents at this time.On 4/7/26 at 2:53 PM, V2 stated residents should always have access to fluids of their choice to help with hydration maintenance. V2 stated if the resident is on some type of dietary restriction, then fluids should be offered at least every two hours, when medications are administered, and at meals depending on their order for fluid restriction. V2 stated he is not sure how often water is passed on the wing but believes it should be done at least daily. V2 stated, I know it's part of the hall checks. The hall monitors are supposed to let us know if everyone has water.On 4/7/26 at 3:25 PM, V1, Administrator, stated residents should have constant access to drinking fluids. V1 stated ice water is passed every shift, but fluids are also offered at every meal, when CNAs do bed checks, and during medication administration times. V1 stated R18, R19, R20 and R21 should have had water pitchers in their rooms. V1 stated the facility does not have a written policy for hydration maintenance for the residents.