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	05/19/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely and factually notify family and the physician of an incident of injury of unknown origin resulting in death for 1 of 6 (R1) residents reviewed for abuse in of a sample of 46.Findings include:R1's admission record documents an admission date of [DATE] and includes diagnoses of Malignant Neoplasm of Unspecified Bronchus or Lung, Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, Adult Failure to Thrive, and anxiety disorder.R1's Minimum Data Set (MDS), dated [DATE], includes a Brief Interview for Mental Status (BIMS) score of 13, indicating R1's cognition was intact. Section GG-Functional Abilities documents R1 required set up or clean up assistance for eating. R1 required substantial/maximal assistance to roll from left and right. R1 was dependent on staff for toileting hygiene, shower/bath self, upper and lower body dressing, putting on /taking off footwear, personal hygiene, sitting to lying on side of bed, sit to stand, chair/bed to chair transfers, and tub/ shower transfers. R1's care plan documents R1 had an increased risk of falls related to weakness and deconditioning. Interventions included anticipate and meet R1's needs [DATE], be sure R1 has call light within reach and encourage her to use it for assistance as needed [DATE], ensure R1 is wearing appropriate footwear nonskid socks and or shoes when mobilizing in wheelchair [DATE], R1 needs a safe environment with : floors free from spills and or clutter; adequate light; a working and reachable call light, the bed in low position at night; handrails on walls, and personal items within reach [DATE], follow facility protocol [DATE], and PT evaluate and treat as ordered as needed [DATE].On [DATE] at 11:20 AM, V15 (R1's Great [NAME], #2 Emergency Contact) was asked if she was notified of R1's fall and death on [DATE] by the nursing facility. V15 stated, No, the funeral home called us and told us he had (died), and I stated this must be a mistake because (R1) is at the facility and we had not heard anything. V15 stated the funeral home man apologized and said he was sorry but R1 had fallen and was deceased . V15 said she told the funeral home man that this is not possible as R1 could not move herself in the bed. V15 stated she called the facility and the night nurse answered and said she did not know why we were not called and said R1 was ok the night before and R1 showed no signs of upcoming death. V15 stated she can't understand why they did not call the family. On [DATE] at 1:10 PM, V1 (Administrator) was asked if she directed the staff to not call the Emergency Contacts for R1. V1 stated, Yes I did tell the nurse not to call the Emergency Contact persons because they never came out to see (R1) and (R1) had Adult Protective Services involved in her case, so I was not sure how or if they were involved with anything. V1 stated, I would do it all over again if I had it to do over.On [DATE] at 10:24 AM, V12 (Physician) was asked if he was aware of R1's recent death. V12 stated, Well, let me pull up my notifications. V12 stated, I have a notification that resident found in floor beside bed with altered breathing. Hospice contacted with ordered to place in bed with oxygen. Resident expired at 12:45 PM. V12 stated this notification is time stamped for [DATE] at 2:39 PM. V12 was asked if he was told about R1 having a trash bag over her face when she was found in the floor. V12 stated, I was not told anything about this at all and what did the police say. This surveyor told V12 the police were not called until the following Monday and the incident happened on a Saturday. On [DATE] at 10:00 AM, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V9 (Licensed Practical Nurse/ LPN) stated, I had talked to (V1) about calling family (Emergency Contacts) and I was told not to call them. I normally call them.On [DATE] at 2:39 PM, V4 (Hospice Clinical Services) stated she called the coroner to inform him of R1's death and the coroner reported to her that he was not told about a fall, he was just told R1 died from cancer. V4 stated then the coroner stated he was going to have an autopsy done on R1 because there may be a different cause of death.On [DATE] at 11:00 AM, V1 was asked in the presence of V3 (Regional Clinical Director) if she told staff to not contact R1's emergency contacts and V1 stated, Yes, I told them not to call those bi****s, and they never came to see her (R1). V3 stated he educated V1 on this subject. R1's Progress Notes document on [DATE] at 10:36 AM, V40 (Licensed Practical Nurse /LPN) documented V39 (R1's Emergency Contact #1/[NAME]) was given update of V41 (Wound Physician), wound care visit on [DATE] site #3. Right posterior calf improved continue with same orders. On [DATE] at 12:45PM, V40 documented V39 was given an update on V41's wound care visit on [DATE]. Site #3 right posterior calf a skin tear has been resolved, V12 (Physician) notified. On [DATE] at 7:53 AM, V42 (LPN) documents during skin assessment this nurse noted scabbed area to right elbow and small skin tear to right lower leg. V41 notified and orders betadine every shift to right elbow and Silvadene, calcium alginate and dry dressing for skin tears, dressings applied per MD orders no pain or discomfort noted. This nurse notified hospice and emergency contact V39. On [DATE] at 3:24 PM, progress notes document this V29 (Social Service Director) spoke with resident about moving her bed next to the window in her room. No concerns at this time. Emergency Contact was made aware via voice mail.R1's [DATE] at 8:36 PM progress note authored by V38 (LPN) documented, This nurse received a call from (V15 R1's 2nd Emergency Contact) regarding (R1's) passing. Very upset at the fact that they had to find out from the funeral home of resident passing. Questioning why facility had not made contact with them. This nurse looked up (R1's) profile and noted that this caller was emergency contact number 2 and her mother was listed as emergency contact 1. This nurse confirmed that resident had passed and explained it was very unexpected. (V15) stated they did not receive a call from hospice either. Stated they would contact management on Monday to discuss matter. This nurse apologized, condolences given, and call ended. (V2 Director of Nursing/DON) and (V16 Assistant Director of Nursing/ADON) and (V1) notified of this encounter.The was no reproducible evidence located in R1's clinical record that documented R1's family/emergency contact was called on [DATE] and made aware R1 had expired.Policy titled Change in Resident's Condition or Status, dated revised 2021, documented, .our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status. Under Policy Interpretation and Implementation . #2 A significant change of condition is a decline or improvement in the resident's status that . b. Impacts more than one area of the resident's health status . 3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative when . The resident is involved in any accident or incident that results in an injury including injuries of unknown source .

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from sexual abuse for 2 (R3 and R10) of 6 residents reviewed for abuse in a sample of 46. This failure resulted in R10 feeling intimidated and scared for her safety.Findings include:1. R10's admission Record documented an admission date of [DATE], with diagnoses including depression, major depressive disorder, and anxiety disorder. R10's [DATE] Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment.R4's admission Record documented an admission date of [DATE], with diagnoses including vascular dementia. R4's [DATE] MDS documented a BIMS 9, indicating moderate cognitive impairment.On [DATE] at 11:20 AM, R10 was sitting in the dining room and was alert and oriented to person, place, time, and situation. R10 said about a week prior to this interview, unsure of exact date, R10 was lying in bed, and a man had crawled in bed with her and was rubbing her legs. R10 said she started screaming and told him to leave. R10 said she was not sure of the man's name but could point him out. R10 said the man was not currently in the dining room but R10 had seen him earlier in the day. R10 stated she was intimidated and scared by being woken up by a strange man in my room with his hand under my covers rubbing me. R10 was asked if she had reported this incident to any staff and R10 said she had reported this incident to that dark haired lady (V1, Administrator) earlier that morning when that dark haired lady was asking if R2 had exposed himself to R10.On [DATE] at 11:46 AM, R10 was still sitting in the dining room. R10 was asked if the man that had touched her was also in the dining room and R10 pointed at R4. R4 was pleasantly confused and not a reliable historian. R10 confirmed that dark haired lady was V1.On [DATE] at 1:00 PM, R10 was asked if R10 used her call light for assistance when R4 was in her room and R10 said no she had just started screaming at R4. R10 said after she started screaming at R4, R4 got back in his wheelchair and left her room.On [DATE] at 9:15 AM, R10 was alert and oriented to person, place, time, and situation. R10 said she had spoken to V1 again and had been asked about the incident with R4. R10 said she told V1 R10 was asleep and that man, the one I pointed out in the dining room (R4) was in my room with his hand under my covers rubbing my legs. R10 was asked if R4 got in bed with R10 and R10 said she was not sure if R4 was in bed with her or on the side of the bed because R10's bed was not very big. R10 stated, Who knows what he would have done if it hadn't woken me up. R10 said she started screaming and must have scared R4 because R4 got back in his wheelchair and left R10's room. R10 said the incident occurred during the night but the light over R10's door was on and that is how R10 was able to see R4.R4's [DATE] MDS documented R4 required partial/ moderate assist with lying to sitting on side of bed, dependent with sit to stand and chair/bed-to-chair transfer, and not applicable with walking 10 feet.On [DATE] at 2:04 PM, R4 was observed independently walking to the bathroom in his room. R4 was redirected back to bed by staff. After staff left R4's room, R4 was observed to independently get out of bed and start walking back to the bathroom in his room.On [DATE] at 1:08 PM, V13 (Certified Nursing Assistant/ CNA) said R4 was able to get up and transfer himself to his wheelchair or to the bathroom. V13 said she had seen R4 wandering into other residents' rooms and R4 had to be redirected.On [DATE] at 11:26 AM, V1 said R10 did not tell V1 R4 had inappropriately touched R10. V1 said R10 had only told V1 R4 had patted R10 on the leg in the dining room.R4's care plan did not document any behavioral plan of care.R10 and R4's [DATE] Final IDPH (Illinois Department of Public Health) Incident and/or Abuse Notification final report documented, On [DATE] at 1126 am Administrator went to (R10) to get a statement from her on another reportable. (R10) stated a man come into her room. Administrator asked (R10) is the man in the dining room and (R10) looked around and stated no. Administrator told (R10) that she would return at lunch to see if she can point out the resident. Then surveyor reported to the administrator (R10) stated (R4) got into her bed and touched (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	her leg. Administrator explained to surveyor what (R10) had just told her. Administrator went back to (R10) and asked her what surveyor just told Administrator and she said yes it was (R4). During the interview with (R10) she stated to the Administrator I don't think he actually got into my bed, I just felt his hand and arm in my bed. (R10) said [sic] she jerked away and hollered. The roommate did verify this incident happened upon interview. Both (R10) and her roommate confirm in interview that (R4) left the room without difficulty or incident. The next morning while the nurse was giving (R10) her meds (R10) seen (R4) and she asked (R4) about him touching her leg and (R4) stated I just wanted to say hi. (R4) has a Bims of 3. (R10) said there has been no other incidents since then and the roommate did verify (R4) has not been back into their room. The ADON assessed (R10) with no emotional distress noted. The facility does find the incident occurred but cannot determine if the conduct was of sexual intent. The facility did interview other residents and staff and no one has reported any other incidents with (R4). 2. R3's admission Record documented an admission date of [DATE], with diagnoses including difficulty in walking, anxiety disorder, and major depressive disorder. R3's [DATE] Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R3 was cognitively intact.R2's admission Record documented an admission date of [DATE], with diagnoses including Alzheimer's disease and dementia. R2's [DATE] MDS documented a BIMS score of 3, indicating R2 was severely cognitively impaired.On [DATE] at 9:48 AM, R3 was alert and oriented to person, place, time, and situation. R3 said on the day R1 expired ([DATE]), R2 came into R3's room and placed his dirty socks on my bed, pulled down his pants, and was feeling around in his underwear. R3 said she got loud with R2 telling him to leave and to get his dirty socks off her bed. R3 said after getting loud with R2, R2 pulled up his pants, picked up his socks, and left her room. On [DATE] at 10:18 AM, R3 said on the day R1 expired ([DATE]), R3 told V1 about the incident with R2 earlier that day.On [DATE] at 1:28 PM, V2 (Director of Nursing/ DON) said 2 to 3 weeks prior to this interview, a person from R2's Assisted Living Facility came to the facility to screen R2 for readmission. V2 said this person had asked if R2 had been taking his clothes off and V2 told her no. V2 said the person acted like she was surprised. V2 said the facility was not aware of R2 having any behaviors prior to R2's admission.On [DATE] at 11:06 AM, V26 (Registered Nurse/ RN) said she had seen R2 pulling his pants down in the hallway once before being redirected by staff and assisted to the bathroom. V26 said R2 wanders into other resident rooms and has to be redirected. V26 said R2 will go in and out of any door he could find while constantly wandering. On [DATE] at 11:01 AM, V36 (Assisted Living Social Services Director) said she had gone to the facility to screen R2 for readmission. V36 said R2 had a history of undressing in common areas and wandering into other resident rooms and undressing. V36 said no one from the facility had contacted her to inquire about R2's behavioral history.On [DATE] at 11:14 AM, V37 (Assisted Living RN) said R2 would disrobe in public and in other resident's rooms. V37 said R2's disrobing behavior had worsened prior to discharge. V37 said R2 was very handsy in a loving way not really a sexual way.R2's care plan documented no behavioral plan of care. R2 and R3's [DATE] Final IDPH Incident and/or Abuse Notification documented, On [DATE] a resident (R3) made an allegation of a resident being inappropriate by lowering his pants down in front of her. Upon more through [sic] investigation the facility has found the alleged resident (R2) did not expose himself to (R3). The alleged resident has a diagnosis of Alzheimer's and has a BIMS of 3. (R2) does not recall the allegation. There has not been any other allegations of this type of behavior. The facility has conducted interviews with other staff members and residents and this behavior has not been noted. The facility finds the allegation unsubstantiated. No further incidents of this behavior has been noted.R2 and R3's [DATE] Final IDPH Incident and/or Abuse Notification documented, ADDENDUM On [DATE] a resident (R3) made an allegation to our Regional Clinical Director (RCD) and a State Surveyor of a resident coming into her room only to the bathroom area being inappropriate by lowering his pants down in front of her. (RCD) asked the resident (R3) did he expose himself to you and (R3) stated no he did not he had underwear on. She told him to leave the room and (R2) left the room. (R3) further stated in this interview that (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(R2) has never been aggressive toward her and that he left the room without any complications. During the facilities [sic] thorough investigation the facility has found the alleged resident (R2) did drop his pants and exposed his (incontinence brief) in the presence of (R3) but he did not expose his genitals or buttocks to (R3), however the facility is unable to dietermine [sic] if this was sexual in nature. The alleged perpetrator does has [sic] a diagnosis of Alzheimer's and has a BIMS of 3 and does not recall the allegation. The facility has conducted interviews with other staff members and residents and this behavior has not ever been displayed by (R2) prior to this occurrenc [sic] or since this incident.On [DATE] at 9:32 AM, V31 (Chief Executive of Operations/ CEO) stated she expected staff to know the structural details of investigations and reporting allegations of abuse. The facility's [DATE] Abuse and Retaliation Policy Prevention Program documents, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of good and services by staff, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident-sensitive and resident-secure environment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report abuse timely to the State Agency and to local law enforcement for 2 (R1 and R3) of 6 residents reviewed for abuse out of a sample of 46. This failure has the potential to affect all 114 residents residing in the facility.Findings include:1. R1's admission record documents an admission date of [DATE] and includes diagnoses of Malignant Neoplasm of Unspecified Bronchus or Lung, Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, Adult Failure to Thrive, and anxiety disorder. R1's Minimum Data Set (MDS), dated [DATE], includes a Brief Interview for Mental Status (BIMS) score of 13, indicating R1's cognition was intact. R1's Initial IDPH (Illinois Department of Public Health) Incident and/or Abuse Notification report was received by IDPH via email from V3 (Regional Clinical Director/ RCD) on [DATE] at 4:04PM. This report documents the incident date and time of [DATE] at 12:30 PM. The description of the incident documents, On [DATE] (R1) was noted to be in floor next to her bed. The nurse immediately assessed the resident. Only obvious injuries were skin tears to left and right elbows. Resident on hospice with no previous falls noted. Residents BIMS is a 13. Hospice notified and gave orders to put resident back to bed and place oxygen. Resident passed away shortly after. Hospice notified. Resident has no POA (Power of Attorney) and is her own responsible party. Comprehensive investigation was initiated and a final report to follow in 5 business days. Under Type of Incidents', the box is marked as other and documents Death occurred shortly after being found on the floor.R1's Final IDPH Incident and/or Abuse Notification report by V3 documents the following: On [DATE] at 1230, (R1) was noted to be on the floor next to her bed. The nurse immediately assessed the resident. Only obvious injuries were skin tears to left and right elbow. Resident on hospice with no previous falls noted. Residents BIMs is a 13. Several staff members were interviewed for the investigation. A complete reenactment was conducted with staff present at the time resident was found. Resident was noted to be in the middle of the bed at 1145. Resident was sitting up at that time to get ready to eat lunch. Staff went to give resident her lunch tray and resident was noted to be on the floor at 1230 laying on her stomach with her head in the nearby trash can. Trash can had a liner in with no other trash noted. Trash can liner noted to have a hole in it. Staff immediately removed trash can and nurse came to assess. Nurse thought they felt a radial pulse. Hospice notified and gave orders to put resident back in bed and place resident on oxygen. Resident is a DNR/comfort focused treatment. Vitals were taken with resident on the floor with no vitals noted. Hospice notified. Funeral home was notified of residents passing. Residents' roommate interviewed for the investigation and stated I didn't hear anything, I was in the bathroom. I didn't hear her yell or anything. At this time, we do not know what caused the resident to fall out of bed or the cause of death. An autopsy is being performed. Resident is dependent with care, transfers and has no history of falls prior to this incident. Prior to fall at 11:45, resident was able to move head and arms and respond to staff per baseline. Resident dependent for most functional and bed mobility tasks. (Name of city) police department was notified on [DATE] of the incident. Resident had no POA or responsible party. Emergency contacts called the facility on [DATE] in the evening and had been notified by the Coroner.On [DATE] at 1:10 PM, V1 (Administrator) stated she tried to call the police on Monday [DATE] to get a number like a run number that we get when we have to call in abuse and get a number that proves we have called them. V1 stated the woman said that they don't give us, the facility, numbers for this stuff and so I got mad and hung up on her. V1 stated she then called and spoke to the Assistant Chief of Police and stated she told them R1 had died and fell out of bed. V1 was asked if she told them about R1's head being in the trashcan with a trash liner (plastic bag) over her face. V1 stated, No I did not tell them that. V1 was asked why she did not include that information and V1 stated, I felt that was too much information to give them. V1 was asked why she waited until Monday (two days later) to call the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	police and V1 stated, I was doing what my boss told me to do, and she thought there was no regulation to force us to call the police. V1 was asked if she was aware of a part of her abuse policy that directs them to call the police when this type of incident happens and V1 stated, Well, I did not know at the time and again I was following what my boss told me. 2. R3's admission Record documented an admission date of [DATE], with diagnoses including difficulty in walking, anxiety disorder, and major depressive disorder. R3's [DATE] Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R3 was cognitively intact.R2's admission Record documented an admission date of [DATE], with diagnoses including Alzheimer's disease and dementia. R2's [DATE] MDS documented a BIMS score of 3, indicating R2 was severely cognitively impaired.On [DATE] at 2:40 PM, R1's roommate R3 was asked if she heard anything going on when R1 had the fall and R3 stated, No, I was too busy getting that dirty old man (R2) out of my room. R3 stated, He (R3) came in my room and started pulling his pants down and exposed himself to me and I yelled and told him to get out. This interview was conducted with V3 (Regional Clinical Director) present.On [DATE] at 9:48 AM, R3 was alert and oriented to person, place, time, and situation. R3 said on the day R1 expired ([DATE]), R2 came into R3's room and placed his dirty socks on my bed, pulled down his pants, and was feeling around in his underwear. R3 said she got loud with R2 telling him to leave and to get his dirty socks off her bed. R3 said after getting loud with R2, R2 pulled up his pants, picked up his socks, and left her room. On [DATE] at 10:18 AM, R3 said on the day R1 expired ([DATE]), R3 told V1 (Administrator) about the incident with R2 earlier that day.An Initial IDPH Incident and/or Abuse Notification report was received by IDPH via email on [DATE] documenting: On [DATE] at approximately 3:50 PM a resident made an allegation of a resident possibly being inappropriate lowering his pants. Resident was immediately removed from her and put on 15 min checks. Resident was assessed, with no findings of injury or emotional distress. This report documents R2 for the name of the resident but does not document R3's name on the report or identify R3 as the victim. This report documents police was notified at that time ([DATE]).The facility's [DATE] Daily Census documented 114 residents residing in the facility.The facility's [DATE] Abuse and Retaliation Policy Prevention Program documented, Any allegation of abuse, retaliation, or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to decide whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time or the incidence of injuries over time. If classified as an injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given, and notification of the resident's physician, responsible party. The Department of Public Health will be notified. Time frames for reporting and investigating abuse will be followed. When an allegation of abuse, exploitation, neglect, mistreatment, retaliation, or misappropriation of resident property has been made, the administrator, or designee, shall notify the Department of Public Health's regional office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property has been reported to the administrator and is being investigated. The facility shall also contact local law enforcement authorities. in the following situations. sexual abuse of a resident by a staff member, another resident, or visitor. when a resident death has occurred other than by disease process. If there is a reasonable suspicion that a crime has been committed that results in serious bodily harm, a report (continued on next page)

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	145863	A. Building B. Wing	05/19/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	shall be made to local law enforcement and IDPH immediately. If a reportable incident or allegation results in the death of a resident, this facility shall, after contacting law enforcement, notify the IDPH Regional Office by phone. This means that this facility will speak with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If unable to contact the Regional Office, this facility will notify the Department's toll-free complaint registry hotline at [PHONE NUMBER].

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough investigation and report factual information of an injury of unknown origin that resulted in R1's death and failed to investigate allegations of sexual abuse for 3 of 6 residents (R1, R3, R10) reviewed for abuse in a sample of 46. The facility's failure has the potential to affect all 114 residents residing in the facility by failing to protect them from potential abuse.The Immediate Jeopardy began on [DATE] at 12:00 PM when R1 was found expired in the floor next to her bed with her head in a trash can and a plastic trash bag covering her face. V1 (Administrator) and V3 (Regional Clinical Director) were notified of the Immediate Jeopardy on [DATE] at 1:00 PM. The surveyor confirmed by observation, interview, and record review, that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Findings include:1.R1's admission Record documents an admission date of [DATE], with diagnoses of Malignant Neoplasm of Unspecified Bronchus or Lung, Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, Adult Failure to Thrive, and anxiety disorder. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 13, indicating R1's cognition is intact. Section GG-Functional Abilities documents R1 required set up or clean up assistance for eating, partial/moderate assistance for oral hygiene and toilet transfers, substantial/maximal assistance to roll from left and right, and was dependent on staff for toileting hygiene, shower/bath, upper and lower body dressing, putting on /taking off footwear, personal hygiene, sitting to lying on side of bed, sit to stand, chair/bed to chair transfers, and tub/ shower transfers. R1's Care Plan documents R1 had an increased risk of falls related to weakness and deconditioning. Documented interventions include: anticipate and meet R1's needs, be sure R1 has call light within reach and encourage her to use it for assistance as needed, ensure R1 is wearing appropriate footwear nonskid socks and or shoes when mobilizing in wheelchair, R1 needs a safe environment with : floors free from spills and or clutter; adequate light; a working and reachable call light, the bed in low position at night; handrails on walls, and personal items within reach, follow facility protocol, and PT evaluate and treat as ordered as needed all initiated [DATE]. R1's Care Plan also documents that R1 has admitted to hospice for end of life care with an initiation date of [DATE]. R1's Initial IDPH (Illinois Department of Public Health) Incident and/or Abuse Notification report was received by IDPH via email from V3 (Regional Clinical Director/ RCD) on [DATE]. This report documents the incident date and time of [DATE] at 12:30 PM. The description of the incident documents, On [DATE], (R1) was noted to be in floor next to her bed. The nurse immediately assessed the resident. Only obvious injuries were skin tears to left and right elbows. Resident on hospice with no previous falls noted. Residents BIMS is a 13. Hospice notified and gave orders to put resident back to bed and place oxygen. Resident passed away shortly after. Hospice notified. Resident has no POA (Power of Attorney) and is her own responsible party. Comprehensive investigation was initiated and a final report to follow in 5 business days. Under Type of Incidents', the box is marked as other and documents Death occurred shortly after being found on the floor. R1's Progress Note, dated [DATE] at 12:30 PM authored by V9 (Licensed Practical Nurse/LPN), documents CNA's (Certified Nurse Assistant's) notified this nurse that resident was on floor beside bed. Once this nurse entered the room resident noted to be laying on her stomach with resident not responding to staff. Faint pulse noted with contact made to (name of hospice company) to place O2 (oxygen) on resident and assist back to bed at this time with resident assisted. During process of (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	minutes later, V8 reported that R1 had passed. V7 stated R1 wore oxygen off and on as needed. V7 stated when she had seen R1 last she had to help her turn over in bed because she could not do it by herself. V7 stated she asked if the nursing home called the coroner and family and V7 stated that V8 told her that they had called both. V7 stated she ended up calling the funeral home around 3:00 PM because the nursing home stated they did not know which funeral home R1 preferred. On [DATE] at 3:52 PM, V3 (Regional Clinical Director/ RCD) stated he was not present in the facility on [DATE] at the time of R1's death. V3 stated V1 (Administrator) called him at 12:50 PM and informed him R1 rolled out of bed and hospice told them to put her to bed and put oxygen on R1 and then R1 passed away. V3 stated V1 said R1 possibly hit trash can on her way down. V3 stated the nurses' stories are all jacked up. V3 was asked if he verified nurses' notes and he stated, they are messed up. V3 stated the nurses working were V8 (LPN) and V9 (LPN). V3 stated it sounds like at 11:45 AM, R1 was checked on and set up in bed for lunch. Then at 12:30 PM, a CNA went in to give R1's roommate her tray and noticed R1 was not in her bed so the CNA went out and asked the other CNA where R1 was. That is when both CNA's went in to R1's room and saw R1's feet on the other side of bed and R1 was lying on her stomach and the trash can was over her head. V3 stated the CNA's were not sure about a trash bag. V3 stated they called V9 (LPN) to the room and V8 (LPN) came to help. V3 was asked if R1 had side rails and V3 stated he was not sure. V3 was asked if they ever call the ambulance for hospice residents and V3 stated no we call hospice and the family to see if they want the resident sent out. V3 stated he wasn't sure if the doctor was called but he knew hospice was called. V3 stated he had been in the facility investigating this incident yesterday ([DATE]) and continues on today ([DATE]). V3 stated, I believe she had a faint pulse, but I am not sure if they should have called the ambulance. V3 stated he was not sure who wanted an autopsy and V1 had talked with the coroner. V3 stated R1 was dependent on staff for all of her care except she could feed herself. V3 stated R1 required the staff to turn and reposition her every 2 hours. V3 stated R1 never had any falls. On [DATE] at 4:41 PM, V1 (Administrator) stated she was not in the facility when R1 fell and passed away, but she did receive a call from V8 (LPN). V1 stated she came to the facility and got staff interviews/statements and started an investigation. V1 stated it was around 12:50 PM and she arrived just a couple minutes after the call. V1 stated she was told R1 was in her bed when her nurse, V9 (LPN), went and checked on her around 11:30 AM. V1 stated V9 said R1 appeared ok at that time. V1 stated at 11:45 AM, R1's roommate's (R3) call light was activated, and a CNA went in to help the roommate (R3) then got R1 ready for lunch. V1 stated the CNA's started passing the noon time meal trays. V1 stated V17 (CNA) took R3's tray into the room and noticed R1 was not in her bed. V1 stated V17 saw R1's feet and went and got the other CNA and stated R1 was lying on the floor on her belly with her left arm up against the wall and had a skin tear to her arm. V1 stated they moved the trash can and moved R1 on her side. V9 was in the room at this time and noted R1 to have a faint pulse. V1 stated V8 went to check on R1's code status and called hospice and hospice said R1 was comfort care and to put R1 back to bed and apply oxygen. V1 stated the staff then lifted R1 back to bed and applied the oxygen and they felt a pulse at that time and V11 (CNA) told V1 she saw R1 breathing. V1 stated the trash can was against the wall, and the staff said R1's head was in the trashcan. V1 stated she looked in the trash can and there was a plastic bag in the trash can with a large hole in the bag. V1 stated she is not sure who wanted an autopsy. V1 stated she instructed the staff not to call R1's family as they are only emergency contacts and they never came to see R1, and she did not know them. V1 stated R1 was under APS (Adult Protective Services) so she wasn't sure if the emergency contact persons were involved with all of that. V1 stated they have been investigating the incident but are not sure how R1 fell out of bed. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On [DATE] at 10:00 AM, V17 (CNA) stated she was working on [DATE] on a different hall but went down to R1's hall to help get ready to pass the noon time meal trays. V17 said she answered R1's roommate's (R3) call light. V17 stated she really didn't pay attention to R1 as she was helping R3 with her oxygen concentrator as she needed to use the bathroom. V17 stated she went back out and was starting to pass meal trays and when she came to R1's room she noticed R1 was not in bed, so she went and asked CNA's (V11 and V13) where R1 was. V17 stated she and V11 then went into R1's room and she saw R1 on the floor. V17 stated V11 got down on the floor with R1, and she (V17) summoned for more help. V17 stated she stood back out of the way once she came back to R1's room and she didn't know if they put R1 to bed using a sheet or how they put her back to bed. On [DATE] at 2:40 PM, V3 (Regional Clinical Director/ RCD) was asked if R1 had side rails and V3 stated he was not sure. V3 was asked if he came in to investigate R1's death and V3 stated he came in on the following Monday ([DATE]). V3 was asked to take this surveyor to R1's room. V3 went to V2 (Director of Nursing/ DON) at the nurse's station and asked what room was R1's room. V3 and this surveyor went to the room and looked at the room. R1's roommate, R3, was asked if she heard anything going on when R1 had the fall and R3 stated, No, I was too busy getting that dirty old man (R2) out of my room. R3 stated, He (R2) came in my room and started pulling his pants down and exposed himself to me and I yelled and told him to get out. R3 stated she then went to the bathroom and had her oxygen concentrator nearby and she did not hear anything. R3 stated before she went into the bathroom R1 was sitting up in bed and in the middle of the bed getting ready for lunch. R3 stated she was in the bathroom for a long time and when she was coming out she saw about 5 people running in the room and they were on the other side of R1's bed. R3 stated she could not see R1. R3 stated she had no idea what happened. V3 was present and witnessed this interview with R3. On [DATE] at 10:15 AM, V9 (LPN) stated she was the charge nurse for R1 on [DATE]. V9 stated she had given R1 her medications that morning and again at about 11:30 AM and R1 was ok. V9 stated she was summoned to R1's room by staff due to R1 being on the floor. V9 stated she ran to check and see if R1 was a DNR (Do Not Resuscitate) and then ran to the room. V9 stated when she got to the room the trash can and trash bag had already been removed from her head. V9 stated another nurse ran and called hospice. V9 said she didn't know how R1 got on the floor as R1 could not move the lower part of her body. V9 stated V1 got to the facility quickly and started interviewing people. On [DATE] at 1:10 PM, V9 (LPN) was asked if she called the emergency contacts for R1 upon her death and V9 stated, I was going to but (V1) told me not to call them because they never came out to see her (R1). V9 was asked to clarify if R1 had a pulse or was breathing while R1 was lying on the floor and V9 stated, We checked her vital signs with the vital sign machine while she was on the floor and there were no vital signs to obtain. V9 stated they checked R1's vital signs once she was moved to bed and still there were no vital signs at all, no blood pressure, no pulse, no respirations, and pulse oximeter did not show anything. V9 stated R1's temperature was like 95 degrees. V9 was asked if she called the physician (V12) and V9 stated no she just sent him a message through the electronic notification system. V9 stated, I just know it was crazy, and I don't understand how (R1) rolled out of bed and landed in the trash can and the bag up over her head like they told me it was. On [DATE] at 2:33PM, V11 (CNA) stated she and V13 (CNA) were the CNA's on R1's hall and had cared of R1 on [DATE]. V11 stated we got R1 repositioned and ready for lunch. R1 was placed on her back in a sort of sitting position with her bedside table over her. V11 stated normally R1 could only move her hands a little bit but not her lower extremities. V11 stated R1 had no complaints and was her normal self and this was about 11:30 AM. V11 stated she was passing trays and heard V17 (CNA) ask V13 where R1 was and V13 stated she is in her bed and V17 stated no she is not. Someone said (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	back to bed and applied oxygen as instructed by hospice. On [DATE] at 1:58 PM, V11 was reinterviewed and stated she was working on R1's hall on [DATE] when R1 was found in the floor. V11 stated she had just been in R1's room around 11:30-11:45 AM getting her ready for lunch. V11 stated R1 was dependent on staff for all ADL's (Activities of Daily Living) except she could feed herself after set up. V11 stated R1 did not like disposable undergarments on while she was in bed. V11 stated R1 could not use her legs at all. V11 stated, (V17) yelled and I went into (R1's) room and noticed (R1) was in the floor with her head in a trash can with the trash bag covering her face. V11 stated there was also blood from the skin tear to R1's left elbow. V11 stated R1's head was positioned in the trashcan with her head to the side on her left side. V11 stated R1 would have had a hard time breathing with the trash bag over her face like it was. V11 stated she gently removed the trash bag and trashcan and noticed R1's face and hands were blue. V11 stated R1 was nonresponsive. V11 stated she thought she felt maybe a faint pulse but V8 checked it and said he did too. V11 stated R1 never regained consciousness. V11 stated, We put her to bed and there were no vitals at that time. V11 was shown her typed witness statement provided by V1 and V11 stated, this is incorrect. V11 was asked when she gave her statement to V1 did she include the details of the trashcan and trash bag and V11 stated, Yes, I told her exactly all about that. V11 was asked if she knew why it was not in the typed statement and V11 stated, No, I have no idea. V11 was asked if she had seen the typed statement and V11 stated No. V11 was asked if R1 was still breathing and V11 stated, No, but I may have seen a breath when we moved her but not really breathing. V11 was asked if her typed statement was correct and V11 stated, It is incorrect. On [DATE] at 2:10PM, V1 stated, I tried to call the police on Monday [DATE] to get a report run number like that we get when we have to call in abuse and get a number that proves we have called them. The woman (police dispatcher) said that they don't give us numbers for this stuff and so I got mad and hung up on her. V1 stated she then called and talked to the assistant police chief and stated she told them that had died and fell out of bed. V1 was asked if she told them about R1's head being in the trashcan with a trash liner (plastic bag) over her face, V1 stated, No I did not tell them that. V1 was asked why she did not include that information when reporting to the police and V1 stated, I felt that was too much information to give them. V1 was asked if she typed out the witness statements from the staff and V1 stated, yes, I did. V1 stated, I came in when they called and I sat at the front desk and took their statements and wrote them out, then I typed them because my writing was so bad. V1 was asked why V11's typed witness statement did not include the part about the trash can and the plastic bag. V1 stated, I guess I just left that part out. V1 was asked why that was left out and V1 stated, I don't know. V1 was asked why she put that V11 stated R1 was still breathing when R1 was on the floor and V1 stated, I know (V11) told me that. V1 was asked if she went to R1's room when she got to the facility and V1 stated, not for a while. V1 said she came in and sat at the front desk and did interviews with all of the staff. V1 said she went to the room later on, but they had cleaned up and R1 was in bed. V1 was asked if she directed the staff to not call the Emergency Contacts for R1 and V1 stated, Yes, I did tell the nurse not to call the Emergency Contact persons because they never came out to see (R1) and (R1) had Adult Protective Services involved in her case, so I was not sure how or if they were involved with anything. V1 stated, I would do it all over again if I had a do over. V1 began crying and stated, I don't want you to think I am a liar or that I am trying to hide anything with this situation. V1 asked why she waited until Monday, [DATE], to call the police and V1 stated, I was just doing what my boss told me to do, and she thought there was no regulation to force us to call the police. V1 was asked if she was aware of a part of her abuse policy that directs them to call the police when this type of incident happens and V1 stated, Well, I did not know at the time and again I was following what my boss told me. V1 was asked why information was not being disclosed throughout this investigation and V1 stated, I was controlling the investigation and (continued on next page)

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	145863	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Marion	1301 East Deyoung Marion, IL 62959

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	protecting the facility. V1 confirmed that her boss was V31 (Chief Executive Officer/ Operations Consultant). On [DATE] at 10:30 AM, V1 presented this surveyor with the witness statements that were handwritten by V1 on [DATE] and were signed by the witness/staff making the statements. V1 stated she then typed out the statements and they were included in R1's investigation file that was provided to this surveyor on [DATE]. V1 stated she typed them out because what she had written (on [DATE]) was chicken scratch and nobody could read them. V1 stated these hand written statements were sent to V31 as well. The handwritten witness statements were reviewed and compared to typed statements that were in the R1's investigation file. The handwritten witness statements document the following: V9's (LPN) statement dated [DATE] at 12:50 PM: girls came down hall. Girls said head in trash can, girls had pulled her out and bag was around her head. Nurse did not see this. Resident on floor when nurse entered room towards the window on left side of face. Left arm big skin tear, fresh blood. Still warm faint pulse. On hospice DNR. At 11:30AM she was sitting in bed nurse seen. This statement is signed by V9. V9's typed witness statement did not document the details regarding the trash can and bag. V11 (CNA) statement dated [DATE] at 1:25PM: Passing lunch trays. (V17) asked where (R1) was, and I told her room and bed. (V17) said she didn't see her. Someone went in the room and said she was on the floor bleeding. Me and (V17) went together. I pulled trash can and bag was in her mouth. She was sweating. Bed check about 11:30AM. 11:30-11:45AM roommate had call light on and (R1) was leaning to the right, I pulled up and to middle of bed. Called into the room about 12:30PM (V8 LPN) and (V9 LPN) and I put a sheet under her and put her back onto the bed. I felt a pulse, and I saw breathing. (V9) said get vital signs. This statement is signed by V11. V11's typed witness statement did not include the details regarding the trash can and the trash bag being in R1's mouth. V8 (LPN) statement dated [DATE] at 1:33PM: (V8) went down, (R1) was in the floor. Asked if (V9 LPN) checked for a pulse. (V9) said she couldn't feel anything, I checked and found a very faint weak pulse on her left wrist. Ran to check DNR and she was a DNR. Hospice called said if she has a pulse, apply oxygen and went back down and (V9) said no pulse. We put her back in bed. On [DATE] at 9:32 AM, V31 (Chief Executive Officer/ Operations Consultant) stated she was made aware of the incident with R1 on the day of the incident, [DATE]. V31 was asked if she discussed calling the police when this occurred and V31 stated, Yes, but it was a little bit after the fact. V31 stated, I thought and expect my team to know the structural details of investigations, reporting, processes of abuse, and this was unknown origin situation. V31 stated she realized on Monday, [DATE], that the police were not notified so she instructed the team to do so and spoke with and educated V3 (Regional Clinical Director), so V3 then educated V1 about the policy and processes and a QAPI (Quality Assurance and Performance Improvement) was done. V31 was asked if during the investigation, when statements are being obtained, do you expect the investigator to summarize statements and leave important parts out? V31 stated it is perfectly legal for statements to be summarized but not to leave out important details. V31 stated she reviewed the statements and did a 2nd interview with V11, and she stated V11 stated the trash bag was over part of R1's face. V31 was informed that the whole part about the trash bag was left out of V11's typed statement and V31 stated she was not aware of that part. V31 stated the initial statements were like chicken scratch and needed to be summarized. V31 was asked if she was aware that R1's family was not notified, V31 stated, Yes, I was made aware of that and (V3) did a QAPI on that and educated (V1) as well. V31 (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	stated they did a QAPI on reporting and investigating of abuse as well. On [DATE] at 10:24AM, V12 (Physician) was asked if he was aware of R1's recent death. V12 reviewed the electronic notification system and stated he has a notification that Resident found in floor beside bed with altered breathing. Hospice contacted with ordered to place in bed with oxygen. Resident expired at 12:45PM. V12 stated this notification is time stamped for [DATE] at 2:39 PM. V12 was asked if he was told about R1 having a trash bag over her face when she was found in the floor. V12 stated, I was not told anything about this at all and what did the police say. I explained the police were not called until the following Monday, [DATE], and the incident happened on Saturday, [DATE]. V12 stated, This was a crime scene and who knows what happened to this lady. V12 stated, How does anyone know this was not a homicide? V12 stated he feels this should be reported immediately to the police department so it can be looked at even though the crime scene has been disrupted. V12 stated, I feel like this was an intent to hide something. The electronic notification system documentation to V12 dated [DATE] at 2:39PM for R1 documents, Resident found in floor beside bed with altered breathing. Hospice contacted with ordered to place [TRUNCATED]

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility Administrator failed to follow policy and procedures to effectively and efficiently investigate an incident resulting in the death of 1 of 3 residents (R1) reviewed for death in a sample of 46. This has the potential to affect all 114 residents living in the facility.Findings include: R1's Initial IDPH (Illinois Department of Public Health) Incident and/or Abuse Notification report was received by IDPH via email from V3 (Regional Clinical Director/ RCD) on [DATE]. This report documents the incident date and time of [DATE] at 12:30 PM. The description of the incident documents, On [DATE] (R1) was noted to be in floor next to her bed. The nurse immediately assessed the resident. Only obvious injuries were skin tears to left and right elbows. Resident on hospice with no previous falls noted. Residents BIMS is a 13. Hospice notified and gave orders to put resident back to bed and place oxygen. Resident passed away shortly after. Hospice notified. Resident has no POA (Power of Attorney) and is her own responsible party. Comprehensive investigation was initiated and a final report to follow in 5 business days. Under Type of Incidents', the box is marked as other and documents Death occurred shortly after being found on the floor.R1's Progress Note, dated [DATE] at 12:30 PM authored by V9 (Licensed Practical Nurse/LPN), documents, CNA's (Certified Nurse Assistant's) notified this nurse that resident was on floor beside bed. Once this nurse entered the room resident noted to be laying on her stomach with resident not responding to staff. Faint pulse noted with contact made to (name of hospice company) to place O2 (oxygen) on resident and assist back to bed at this time with resident assisted. During process of assisting resident to bed x 3 staff resident noted to not have noted VS (vital signs) at this time. Hospice notified of resident's passing. Hospice nurse stated that resident had no family with the exception of (family member) with MR (mental retardation). Requested for name of funeral home to contact for body to go.On [DATE] at 2:39 PM, V4 (Hospice Clinical Services) stated R1's Hospice notes document a call from V8 (Licensed Practical Nurse/ LPN) stating R1's head was in the trashcan and R1 had suffocated. V4 stated R1 did not die from her cancer, she was doing good. V4 stated she called the coroner to inform him of R1's death and the coroner reported to her that he was not told by the facility (unsure of who called) about a fall, he was just told R1 died from cancer. V4 stated the coroner stated he was going to have an autopsy done on R1 because there may be a different cause of death. V4 stated the coroner was getting ready to have R1 cremated and was thankful V4 called and explained the situation with the fall.On [DATE] at 4:41 PM, V1 (Administrator) stated she was not in the facility when R1 fell and passed away, but she did receive a call from V8 (Licensed Practical Nurse/LPN). V1 stated she came to the facility and got staff interviews/statements and started an investigation. V1 stated she instructed the staff not to call R1's family as they are only emergency contacts and they never came to see R1, and she did not know them. V1 stated R1 was under APS (Adult Protective Services) so she wasn't sure if the emergency contact persons were involved with all of that. V1 stated they have been investigating the incident but are not sure how R1 fell out of bed.On [DATE] at 1:00 PM, R1's investigation file was requested for review and provided by V1. The file contained the Initial IDPH Incident and/or Abuse Notification report dated [DATE], typed witness statements, R1's admission Record, R1's Physician Order for Life Sustaining Treatment (POLST), and R1's Care Plan.V11's typed witness statement, dated [DATE] at 1:25PM, included in R1's investigation file documents the following: Roommate had her call light on, I went to see what she needed. It was about 11:45AM, making sure R1 was ready for lunch. Then they said she was on the floor, I went in to help V17. I moved the trash can. R1 was lying on her belly. The nurse helped me put a sheet under her and we put her back to bed. I felt a pulse, and I saw her breathing.On [DATE] at 2:33PM, V11 (CNA) stated she and V17 (CNA) went in the room and R1 was lying on the floor, and her head was inside with the trashcan, and the trash bag was up against her face. V11 stated she took her hand under the bag and removed it and then gently moved (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	back the trashcan. V11 stated R1's face was blue and so was her hands. V11 stated she tried to feel a pulse and thought she felt one so V8 (LPN) came in the room and he tried to check for a pulse and thought he felt a faint pulse.On [DATE] at 1:58 PM, V11 was shown her typed witness statement provided by V1 and V11 stated this is incorrect. V11 was asked when she gave her statement to V1 did she include the details of the trashcan and trash bag and V11 stated, Yes, I told her exactly all about that. V11 was asked if she knew why it was not in the typed statement and V11 stated, No, I have no idea. V11 was asked if she had seen the typed statement and V11 stated, No. V11 was asked if R1 was still breathing and V11 stated, No, but I may have seen a breath when we moved her but not really breathing. 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V1 stated, I came in when they called and I sat at the front desk and took their statements and wrote them out, then I typed them because my writing was so bad. V1 was asked why V11's typed witness statement did not include the part about the trash can and the plastic bag. V1 stated, I guess I just left that part out. V1 was asked why that was left out and V1 stated, I don't know. V1 was asked why she put that V11 stated R1 was still breathing when R1 was on the floor and V1 stated, I know (V11) told me that. V1 was asked if she went to R1's room when she got to the facility and V1 stated, not for a while. V1 said she came in and sat at the front desk and did interviews with all of the staff. V1 said she went to the room later on, but they had cleaned up and R1 was in bed. V1 was asked if she directed the staff to not call the Emergency Contacts for R1 and V1 stated, Yes, I did tell the nurse not to call the Emergency Contact persons because they never came out to see (R1) and (R1) had Adult Protective Services involved in her case, so I was not sure how or if they were involved with anything. V1 stated, I would do it all over again if I had a do over. V1 began crying and stated, I don't want you to think I am a liar or that I am trying to hide anything with this situation. V1 asked why she waited until Monday, [DATE], to call the police and V1 stated, I was just doing what my boss told me to do, and she thought there was no regulation to force us to call the police. V1 was asked if she was aware of a part of her abuse policy that directs them to call the police when this type of incident happens and V1 stated, Well, I did not know at the time and again I was following what my boss told me. V1 was asked why information was not being disclosed throughout this investigation and V1 stated, I was controlling the investigation and protecting the facility. V1 confirmed that her boss was V31 (Chief Executive Officer/ Operations Consultant).On [DATE] at 9:32 AM, V31 (Chief Executive Officer/ Operations Consultant) stated she was made aware of the incident with R1 on the day of the incident, [DATE]. V31 was asked if she discussed calling the police when this occurred and V31 stated, Yes, but it was a little bit after the fact. V31 stated, I thought and expect my team to know the structural details of investigations, reporting, processes of abuse and this was unknown origin situation. V31 stated she realized on Monday, [DATE], that the police were not notified so she instructed the team to do so and spoke with and educated V3 (Regional Clinical Director), so V3 then educated V1 about the policy and processes and a QAPI (Quality Assurance and Performance Improvement) was done. 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V12 was asked if he was told about R1 having a trash bag over her face when she was found in the floor. V12 stated, I was not told anything about this at all and what did the police say. It was explained the police were not called until the following Monday, [DATE], and the incident happened on Saturday, [DATE]. V12 stated, This was a crime scene and who knows what happened to this lady. V12 stated, How does anyone know this was not a homicide? V12 stated he feels this should be reported immediately to the police department so it can be looked at even though the crime scene has been disrupted. V12 stated, I feel like this was an intent to hide something. On [DATE] at 12:12 PM, V6 (Pathologist) stated he did the autopsy and saw where R1's cancer was bad, but he was unsure about why she fell out of bed unless she passed away and fell over. V6 stated that without the police involvement during the incident, it is hard to rule out anything. V6 stated the police should have been called and they could have shed some light on this incident. V6 stated he will have to put cancer as the primary cause of death, but he will make a note in the file that this death was suspicious of suffocation, but no police report was made to that effect.On [DATE] at 11:20AM, V15 (Family Member/ Emergency Contact) was asked if she was notified of R1's fall and death on [DATE] by the nursing facility. V15 stated, No, the funeral home called us and told us he had (R1) and I stated this must be a mistake because (R1) is in a facility and we had not heard anything. V15 stated the funeral home apologized and said he was sorry but R1 had fallen and was deceased . V15 told the funeral home that this is not possible as R1 would not move herself in the bed. V15 stated she called the facility and the night nurse answered and said she did not know why they were not called and told us that R1 was good the night before and she showed no signs of upcoming death. V15 stated she can't understand why they did not call the family. V15 stated the coroner called (another family member) on Monday, [DATE], and informed her that he needed to do an autopsy due to a suspicious death of possible suffocation. V15 stated hospice told them that before R1's death that she showed no signs of impending death before the incident.R1's Final IDPH Incident and/or Abuse Notification report by V3 documents the following: On [DATE] at 1230, (R1) was noted to be on the floor next to her bed. The nurse immediately assessed the resident. Only obvious injuries were skin tears to left and right elbow. Resident on hospice with no previous falls noted. Residents BIMs is a 13. Several staff members were interviewed for the investigation. A complete reenactment was conducted with staff present at the time resident was found. Resident was noted to be in the middle of the bed at 1145. Resident was sitting up at that time to get ready to eat lunch. Staff went to give resident her lunch tray and resident was noted to be on the floor at 1230 laying on her stomach with her head in the nearby trash can. Trash can had a liner in with no other trash noted. Trash can liner noted to have a hole in it. Staff immediately removed trash can and nurse came to assess. Nurse thought they felt a radial pulse. Hospice notified and gave orders to put resident back in bed and place resident on oxygen. Resident is a DNR/comfort focused treatment. Vitals were taken with resident on the floor with no vitals noted. Hospice notified. Funeral home was notified of residents passing. Residents' roommate interviewed for the investigation and stated I didn't hear anything, I was in the bathroom. I didn't hear her yell or anything. At this time, we do not know what caused the resident to fall out of bed or the cause of death. An autopsy is being performed. Residents are dependent with care, transfers and has no history of falls prior to this incident. Prior to fall at 11:45, resident was able to move head and arms and respond to staff per (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	baseline. Resident dependent for most functional and bed mobility tasks. (Name of city) police department was notified on [DATE] of the incident. Resident had no POA or responsible party. Emergency contacts called the facility on [DATE] in the evening and had been notified by the Coroner.On [DATE] at 6:45PM, V11, CNA, was asked if she remembers when the reenactment was done in regard to R1's incident. V11 stated they did a reenactment on the day it happened. V11 was asked who was present for the reenactment, V11 stated it was just her (V11), V13, CNA, and V1. V11 stated she just showed V1 how R1 was positioned on the floor. V1 was asked if she mentioned the trash can and the trash bag during the reenactment, V11 stated, Yes, I explained all of that. V11 stated the trash bag was in R1's mouth. The facility's Administrator job description dated 2003 under Purpose of Your Job Position section documents, The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal. Stated and local standards, guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. Under the Duties and Responsibilities section documents the following: Ensure that all employees, residents, visitors, and the general public follow the facility's established policies and procedures, Maintain an adequate liaison with families and residents, Inform the Medical Director of all suspected or known incidents of resident abuse, Review accident/incident reports (e.g. falls, injuries of an unknown source, abuse, etc.), and Monitor to determine the effectiveness of the facility's risk management program.The facility policy titled Abuse and Retaliation Prevention Program, dated 1/2026, under section VII. Internal Investigation documents, 3. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to decide whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time or the incidence of injuries over time. If classified as an injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given, and notification of the resident's physician, responsible party. The Department of Public Health will be notified.8. Final Investigation Report. The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident. The final investigation report shall contain the following:. Facts determined during the process of the investigation, review of the medical record, and interview of witnesses, Conclusion of the investigation based on known facts. Under section VIII. External Reporting documents 1. Initial Reporting of Allegations: When an allegation of abuse, exploitation, neglect, mistreatment, retaliation, or misappropriation of resident property has been made, the administrator, or designee, shall notify the Department of Public Health's regional office immediately by telephone or fax. This report shall be made immediately. Informing Local Law Enforcement: The facility shall also contact local law enforcement authorities (i.e., telephoning 911 where available) in the following situations: When a resident death has occurred other than by disease processes. If there is a reasonable suspicion that a crime has been committed that results in serious bodily harm, a report shall be made to local law enforcement and IDPH immediately. If there is a reasonable suspicion that a crime has been committed that is not listed above and does not involve serious bodily injury, then a report to local law enforcement as soon as possible, but within 24 hours of when the suspicion was formed. The resident or resident's representative will also be immediately informed of the report of an occurrence of potential abuse, neglect, exploitation, mistreatment, retaliation, or misappropriation of resident property, and that an investigation is being conducted.The facility's [DATE] Daily Census documented 114 residents residing in the facility.