STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146006	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Anna	315 South Brady Mill Road Anna, IL 62906

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44492 Based on interview, observation, and record review, the facility failed to assess and monitor for proper physical restraint use for 3 of 3 residents (R1, R4, R5) reviewed for restraints in a sample of 6. The findings include: 1. R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Unspecified and Unspecified Intellectual Disabilities. R1's Face Sheet documents discharged from the facility on 3/25/2024. R1's Minimum Data Set (MDS) dated [DATE] documents Section C, Brief Interview for Mental Status (BIMS) score is 13, indicating R1 is cognitively intact. Section GG, Functional Abilities and Goals, documents that R1 is dependent with all activities of daily living. On 3/26/2024, at 10:40 AM, V11 (Certified Nursing Assistant/CNA) stated that she remembers seeing multiple scratch areas to R1's chest like she had dug into her chest. V11 stated that the staff would put socks over her hands to help keep her from scratching. On 3/27/2024, at 8:45 AM, V29 (Licensed Practical Nurse/LPN) stated that he works for this facility and the previous facility that R1 was at. V29 stated that R1 has a chronic behavior of scratching herself. V29 stated that at her previous facility, they would put mittens over her hands to keep her from scratching. On 3/27/2024, at 2:15 PM, V8 (CNA) stated that R1 scratched herself hard one day in the upper chest area. V8 stated that soft, fuzzy socks were placed over her hands to help to keep her from scratching herself. On 3/27/2024, at 3:45 PM, V16 (CNA) stated that R1 would scratch herself with her left hand and soft socks were placed over her hands to help keep her from scratching herself. V16 stated that she reported R1's scratching to V12 (LPN) and that V12 put some cream on her scratches. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/2024, at 2:05 PM, V12 (Licensed Practical Nurse/LPN) stated that it was reported to her on 3/17/2024, that R1 had scratched her chest area. V12 stated that when she assessed her, she noticed R1 had dug into her chest hard. V12 stated that she notified V13 (Primary Physician) about R1's scratches to her chest. V12 stated that V13 told her that this was a long-time behavior of R1 and that her previous facility used mittens to cover her hands to keep her from scratching herself. V12 stated that she told him that mittens are not available at the facility. V12 stated that after she told him that, V13 hung up on her. V12 stated that she found soft, no-show socks and placed them on R1's left hand. V12 stated that R1 would rub her hand against her to remove the sock and continue to scratch herself. On 3/25/2024, at 8:50 AM, V30 (Guardian) stated that she did not visit R1 while she was at the facility. V30 stated that she visited R1 when she was at the emergency roiagnom on [DATE]. V30 stated that she did not disclose any self-injurious behavior to the facility when R1 got admitted to the facility. V30 stated that R1 wore mittens at her previous facility to help keep her from scratching herself. On 3/26/2024, at 2:17 PM, V13 (Primary Physician) stated that he has been involved in R1's care for years, he was her medical provider at her previous facility she lived at for many years. V13 confirmed that R1 did have a history of self- injurious behavior including, scratching, picking and occasionally biting. V13 states that R1 was severely cognitively impaired and has had a severe physical decline over the past year and prognosis has not been great. V13 recalls being notified about a new area to chest from R1 scratching and that he had advised the facility to use mittens as they have used in the past with R1 at her previous residence. V13 denies being informed that the facility did not have mittens or that they were using socks instead. On 4/2/2024 at 10:45 AM, V2 (Director of Nursing/DON) stated that R1 was not assessed for a physical restraint before socks were placed on her hands/wrists. V2 stated that R1 was not assessed to see if she could remove the socks from her hands/wrists. There was no restraint assessment found in R1's medical record regarding socks. 2. R4's Face Sheet documents R4 was admitted to the facility on [DATE] with diagnoses including Encephalopathy, Unspecified and Alzheimer's Disease, Unspecified. R4's Minimum Data Set (MDS) dated [DATE] documents in Section C, a Brief Interview for Mental Status (BIMS) score of 3, indicating that R4 has severe cognitive impairment. Section GG, Functional Abilities and Goals, documents that R4 requires set-up or clean-up assistance with eating; partial/moderate assistance with oral hygiene, upper /lower body dressing, putting on/off footwear, personal hygiene; dependent with toileting hygiene, showering, toilet transfers; and requires supervision or touching assistance with bed mobility, and chair to bed transfer. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Care Plan dated 2/12/2024 documents a Focus area of: (R4) is at risk for falls r/t (related to) Confusion, Psychoactive drug use (Seroquel), Unaware of safety needs with an initiation date of 2/06/2024; Goal: (R4) will not sustain serious injury through the review date. Date Initiated: 02/12/2024 Target Date: 05/12/2024; Interventions: 2/7/2024- Lap buddy while in w/c (wheelchair) to promote proper positioning and comfort while in wheelchair. R4's Care Plan documents a Focus area of: (R4) requires a tray table on geri chair (geriatric reclining chair) during meal times with start date of 3/26/2024; Goal: R4 will remain free from complications related to tray table use on geri chair with a target date of 5/12/2024; Interventions: Evaluate need for restraints and reduce as appropriate; Keep R4 close to areas that are supervised; Provide hazard free environment; Reposition every two hours with a start date of 3/26/2024. R4's Physical Restraint/Device - Initial/Full Comprehensive Evaluation dated 2/7/2024 documents medical reason for device or restraint: lap buddy to aide in positioning. The evaluation further documents that R4 has motor agitation, behavior symptoms, resists treatment, medications, food, poor working balance/coordination, cognitive/communication deficits, and decreased safety awareness/impulsive. On 4/2/2024, at 3:30 PM, V9 (Regional Clinical) stated that he discovered R4 using a lap buddy when he came to the facility on [DATE]. V9 stated that R4 was able to remove the lap buddy but did not have an assessment completed prior to use and consent needed to be obtained. V9 stated that he received consent for the lap buddy on 2/12/2024 and the lap buddy was initiated on 2/7/2024. R4's Physical Restraint/Device - Initial/Full Comprehensive Evaluation dated 3/26/2024 documents tray table to be utilized on geri-chair during mealtimes to increase independence with consumption. Tray table will also serve as a boundary identifier. This evaluation further documents R4's physical restraint/device risks of: history of falls, decreased balance/dynamics, decreased lower extremity strength, poor sitting balance, poor trunk/body control; and documents benefits of: enhances functional status/ability, maintain correct positioning, prevent falling, enhances psychosocial well-being. This evaluation documents that no physician's order was obtained for tray table and documents and initiation date of 2/7/2024. On 4/2/2024, at 3:05 PM, V5 (LPN) stated that R4 has been using the geri-chair with tray table for about a month. V5 stated that R4 uses the tray table at mealtimes and then it is taken off. On 4/2/2024, at 3:10 PM, V2 (DON) stated that R4 has been using the geri-chair with tray table for about a month. V2 stated that the decision was made to use the geri-chair with tray table for meals. V2 stated that R4 was currently in a wheelchair with a lap buddy and during meals, R4 would take his lap buddy and use it to swipe his food and drinks off of the table. V2 stated that R4 would not eat well in the dining room using the lap buddy with his wheelchair. V2 stated that R4's appetite has improved since using the geri-chair with tray table. V2 stated that a lap buddy was used with R4 related to his history of falls at home and a couple of falls after he got admitted to the facility. V2 stated that R4 would try to slide out of his wheelchair and the lap buddy was applied to help aid in positioning for R4. On 4/2/2024, at 3:15 PM, V8 (CNA) stated that R4 has been using his geri-chair with tray table for about a month. V8 stated that R4 only uses it for meals and then the tray table is supposed to be taken off. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R5's Face Sheet documents R5 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity, with psychotic disturbances, Alzheimer's disease with late onset. R5's Care Plan dated 4/10/2023 documents a Focus area of: (R5) is at risk for falls related to Confusion, Deconditioning, Gait/balance problems, Hypotension, Incontinence, Poor communication/ comprehension, Psychoactive drug use, Unaware of safety needs. (R5) is also at risk for falls related to frequent falls prior to admission with fracture and requiring assistance with ADLs. (R5) has a diagnosis of Meniere's Disease which also increases her risk for falls. Goal: (R5) will be free of falls through the review date of 5/26/2024. Interventions: gerichair with table with a start date of 4/10/2023. R5's Physical Restraint/Device - Initial/Full Comprehensive Evaluation dated 3/26/2024 documents tray table to be utilized on geri-chair during mealtimes to increase independence with consumption. Tray table will also serve as a boundary identifier. This evaluation documents risks of: history of falls, decreased balance/dynamics, decreased lower extremity strength, poor sitting balance, poor trunk control, poor body control; and documents benefits of: enhances functional status/ability, maintain correct positioning, prevent falling, enhances psychosocial well-being; least restrictive measures attempted before of tag alarm, foam wedges, and/or pillows. This evaluation documents verbal consent obtained by phone by guardian, there was no physician's order obtained, and an initial date of implication of 6/28/2023. On 4/2/2024, at 3:05 PM, V5 (LPN) stated that R5 uses the geri-chair with tray table at mealtimes and then it is taken off. On 4/2/2024, at 3:15 PM, V8 (CNA) stated that R5 uses the geri-chair with tray table for meals and then the tray table is supposed to be taken off. On 3/25/2024 during observations made at 15 minutes intervals from 1:25 PM to 3:00 PM, R4 and R5 were noted to be reclined in a geri-chair with tray table locked in place in the hallway close to the nurse's station. On 3/25/2024, at 3:30 PM, when this surveyor asked V2 (DON) about why R4 & R5 both had their geri-chairs reclined back with the tray table locked in place, V2 stated, They are not supposed to be in them like that; Once they are done with their meals, the tray table gets taken off. On 4/2/2024, at 10:45 AM, V2 (DON) stated that R4 and R5 are only supposed to utilize their tray table during mealtimes. V2 stated that R4 and R5 are monitored in the dining room during mealtimes. V2 stated that R5's family has bought her a fitted wheelchair and we are awaiting on arrival of her wheelchair. V2 stated that she does random checks throughout the day to make sure there are no residents who are being restrained that have not been properly assessed for a restraint device. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Abuse Prevention Program policy dated 2022 documents in part . Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Purpose .assuring that physical restraints are used sparingly and properly . Physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body. (77 Ill. Adm. Code S 300.330) . The facility's Behavioral Assessment, Intervention, and Monitoring policy (revision date December 2016) documents under the section monitoring step 7 If any devices (restraints) are prescribed, the IDT (Interdisciplinary Team) will monitor the situation to ensure that they are beneficial to the individual (for example, enhancing function and improving symptoms) and are not causing complications or disabling the individual. a. This will be done frequently when such devices are first employed and regularly thereafter for as long as they are used. b. Over time, the staff will reduce the use or remove such devices, or will document why such attempts are not feasible.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on observation, interview and record review, the facility failed to ensure accurate Minimum Data Set (MDS) coding was completed for 3 of 4 (R1, R2 and R4) residents reviewed for accuracy of assessments in the sample of 6. Findings include: 1. R1's Face Sheet documented R1 is a [AGE] year-old female, who admitted to the facility on [DATE]. R1 was discharged on [DATE], after being sent to (Local hospital) emergency roiagnom on [DATE]. Diagnoses listed on this document are Sepsis, unspecified organism, Urinary Tract Infection, site unspecified, bipolar disorder, unspecified, unspecified intellectual disability, unspecified glaucoma. V13 (Physician) is listed as being R1's Primary Care Physician. The only emergency contact listed for R1 on this document is V30 (Guardian/Emergency Contact # 1). R1's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 13, that R1 is cognitively intact. Section A, question A1500 of R1's MDS documents: R1 is currently considered by the state level II Preadmission Screening and Resident Review (PASRR) process to have serious mental illness and/or intellectual disability or a related condition. Question A1510 indicates that R1 has an intellectual disability. Section C-Cognitive Patterns, Section D- Mood, and Section F - Preferences for Customary Routine and Activities indicates the interview was conducted with R1 and that staff assessment was not necessary. Section N-Medications, question N0415. High-Risk Drug Classes: Use and Indication, documents that R1 does not receive any class of medications listed. Section Q-Participation in Assessment and Goal Setting, question Q0110 indicates R1 and R1's family were the only active participants in the assessment process. On 3/26/2024 at 1:51pm, V14 (Certified Nursing Assistant/CNA) stated that she had taken care of R1 a couple of times. V14 also reported that R1 did not say much, she cursed a lot and would ask for tea or soda, but that was about it. On 3/27/2024 at 10:13am, V9 (Regional Director Clinical Reimbursement) stated that people have different levels of cognition at different times of the day or are sometimes more alert on some days. So, a BIMS score could reflect differently at different interviews. V9 stated that V4 (Social Services) conducted R1's interview, and she does a very good job at completing these tasks. On 3/27/2024 at 2:16pm, V4 stated her duties include interviewing staff and residents to complete certain sections of the MDS. V4 stated that she recalls having done a staff interview for R1's MDS. She denies that it would have been likely for R1 to have had a BIMS of 13, which suggests that R1 was cognitively intact. V4 reports that she is fairly certain that she completed the staff interview for Section C- Cognitive Patterns, because R1 really didn't talk much and her ability to communicate was minimal. On 03/28/2024 an attempt was made to review any facilities policy related to assessments, MDS, or care plans, V1 stated the facility follows RAI (Resident Assessment Instrument) guidelines. We do not have any specific guidelines. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/02/2024 at 12:48pm while reviewing a printed copy of R1's MDS dated [DATE], V4 noted the resident interview were completed for sections C, D, and F. V4 stated that this was a mix up on her part, as staff interviews should have been completed because R1 was cognitively impaired and not able to complete interview. R1's Physicians Order Sheet dated 4/02/2024 reveals that R1 was prescribed Clonazepam 0.5mg tablets at bedtime with an order date of 2/20/2024 and a start date of 2/21/2024. R1's Physicians Order Sheet also documents that R1 was also prescribed Eliquis Oral Tablet 5 MG (Apixaban) twice a day with an order date of 2/20/2024, and a start date of 2/21/2024. According to the Center for Medicare and Medicaid Services (CMS) Resident assessment Instrument (RAI) Version 3.0 Manual (last revised October 2023) CH 3: MDS Items [N], section N0400-Medications Received. Residents taking medications in these drug classes are at risk of side effects that can adversely affect health, safety, and quality of life. The following coding instructions are documented in Section N0400: Check B, antianxiety: if anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/reentry if less than 7 days). Check E, anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): if anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. Clonazepam is classified as an antianxiety medication according to the National Institute of health. Eliquis is a Direct Acting Oral Anticoagulant (DOAC) and is classified as a factor Xa inhibitor according to the National Institute of health. An email was received by this surveyor on 3/26/2024 from V30 (Guardian). V30 denied any invitation to any meetings related to the care of and care plan development of R1. On 4/02/2024 at 12:45pm, V5 (Licensed Practical Nurse/LPN) stated she is also the facility MDS coordinator and developing resident care plans is also a part of her job duties. She denies that family was involved in MDS planning for R1. V5 reports she meant to check guardian and accidentally checked family on the section of the MDS that documents who was involved in assessment. She denies any documentation that R1 has any family to contact. 2. R2's Face Sheet documented R2 is a [AGE] year-old female, who admitted to the facility on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Minimum Data Set (MDS) dated [DATE], documents the following diagnosis in it's entirety: Encephalopathy, Urinary Tract Infection, Chronic Kidney Disease, Type 2 diabetes, unspecified, Type 2 Diabetes Mellitus without complications, essential (Primary) Hypertension, unspecified Atrial Fibrillation, Fibromyalgia, morbid (severe) obesity, Arthropathy, unspecified. R2's Minimum Data Set (MDS) dated [DATE], documents a BIMS score of 13, indicating that R2 is cognitively intact. Section GG - Functional Abilities and Goals documents the following: Item GG0120. Mobility Devices is coded that no mobility devices were used in the past 7 days. Item GG0170. Mobility is coded as dependent on admission in the following areas; Rolling left to right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed to chair transfer, toilet transfer, and tub and shower transfer, With all areas assessed related to walking (Columns I-o) coded as Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Column Q1 documents that the resident does not use a wheelchair or scooter. R2's baseline care plan that is unsigned and undated documents R2 is substantial/max assistance in all Functional Abilities and Goals related to Mobility and documents use of a wheelchair. R2 was observed on 03/25/2024-03/27/2024 and again on 04/02/2024, during these observations R2 was sitting in a wheelchair or lying in bed. On 04/02/2024 at 12:30pm R2 stated that she had been using a wheelchair before admission to facility and it is the only way she gets around. R2's Extended Care Facility Transfer Record from (local) Hospital dated 02/23/2024 documents in part: Cardiac Consultation note dated 02/20/2024 documents an admitted [DATE]. In history of present illness documents: R2 is a [AGE] year-old patient with history of diabetes, hypertension who reportedly presented to the emergency room with complaints of generalized weakness chills and falls found to have UTI, acute on chronic kidney disease and also testing positive for C. difficile. She reportedly suffered a cardiac arrest episode from which she underwent AG protocol with resuscitation intubated and transferred to the ICU on the seventh of this month. She was extubated on the 12th and not transferred out to the floor. We have been consulted on account of her reported history of post arrest atrial fibrillation for which she has been reportedly kept on amiodarone, now on Coreg and apixaban for anticoagulation. Her post arrest echo noted a normal ejection fraction. Assessment/Plan 1. Acute respiratory failure, Cardiac arrest, Urinary tract infection, Acute encephalopathy, Acute on chronic renal insufficiency, dehydration, hyponatremia, metabolic acidosis type 2 diabetes, hypertension, Atrial fibrillation, Patient with recent episode of cardiac arrest on amiodarone but maintaining sinus rhythm. She reportedly came out of her rest rhythm of atrial fibrillation but appears maintaining sinus rhythm presently on amiodarone therapy. She still has some resolving acute encephalopathy. She is appropriate responsive when I saw her today. At this time, I would recommend continue current medical therapy with amiodarone. She appears to be on apixaban for anticoagulation for atrial fibrillation. Will follow along during this hospitalization and make recommendations as to her arrhythmia management. Ensure correction of all electrolyte abnormalities. Discharge instructions dated 02/23/2024, document the same diagnosis as cardiology consult. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual (Revision date October 2023) CH 3: MDS Items, Section I: ACTIVE DIAGNOSES outlines the following in part: Intent: The items in this section are intended to code diseases that have a relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered. Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a relationship to the resident's functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. 3. R4's Face Sheet documented R4 is an [AGE] year-old male, who admitted to the facility on [DATE]. R4's Diagnoses listed on this document are encephalopathy, unspecified, Alzheimer's disease, unspecified atherosclerotic heart disease of native coronary artery without angina pectoris, Urinary Tract Infection, site not specified, Sepsis, unspecified organism, unspecified psychosis not due to a substance or known psychological condition, benign prostatic hyperplasia with lower urinary tract symptoms, other retention of urine. R4's MDS dated [DATE], documents a BIMS score of 3, indicating that R4 is severely cognitively impaired. R4's MDS Section H- Bladder and Bowel Question H0100. Appliances, documents that R4 has an indwelling catheter. Item H0300 Urinary Continence, codes R4 as always incontinent (no episodes of continent voiding). According to the Center for Medicare and Medicaid Services (CMS) Resident assessment Instrument (RAI) Version 3.0 Manual (last revised October 2023) and per the instructions listed on the RAI. Section H bladder and bowel, H0300 Urinary incontinence should be coded; Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days. For residents with indwelling catheters. R4's baseline care plan, which is unsigned and undated, documents use of an indwelling catheter. R4's Physician's order sheet dated 4/02/2024, documents the following orders: Foley catheter care every shift every day and nightshift for Cath care. With an order date and start date of 1/31/2024. R4 was observed on 03/25/2024-03/27/2024 and again on 04/02/2024, during these observations, it was noted that there was a urinary drainage bag attached to resident's chair. Drainage bag appeared to be attached to catheter tubing, containing what appeared to be urine. (continued on next page)

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	146006	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Anna	315 South Brady Mill Road Anna, IL 62906

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/26/2024 2:50pm V9 (Regional Director Clinical Reimbursement) reports when he questioned V5 (LPN/MDS coordinator) about accuracy and timely completion of assigned job duties, she stated that she had an extensive list of resident's to complete and just had not gotten to it. V9 also reported that V5 is fairly new and also works on the floor often.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review, the facility failed to complete baseline care plans for 4 of 4 residents (R1, R2, R4, R6) reviewed for assessments in a sample of 6. Findings include: 1. R1'S Face Sheet documented R1 is a [AGE] year-old female, who admitted to the facility on [DATE]. Diagnoses listed on this document are Sepsis, unspecified organism, Urinary Tract Infection, site unspecified, bipolar disorder, unspecified, unspecified intellectual disability, unspecified glaucoma. V13 (Physician) is listed as being R1's Primary Care Physician. The only emergency contact listed for R1 on this document is V30 (Guardian/Emergency Contact # 1). R1 was discharged on [DATE], after being sent to (Local hospital) emergency roiagnom on [DATE]. R1's Physician order sheet dated 04/02/2024 documents: Clonazepam Oral Tablet 0.5 MG Give 1 tablet by mouth at bedtime for bipolar with an order date of 02/20/2024. Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for blood thinner with an order date of 02/20/2024. R1's Minimum Data Set (MDS) with a completion date of 02/27/2024 indicates R1 is currently considered by the state level II Preadmission Screening and Resident Review (PASRR) process to have serious mental illness and/or intellectual disability or a related condition. R1 was referred for a PASSRR level II prior to date of admission. R1's Baseline Care Plan is Undated and Unsigned by Resident, Representative or staff completing plan. Documents admitted as 02/20/2024. The following applicable areas were not completed and left blank: Name of resident's representative, Advanced Directives / Code Status, Active diagnoses contributing to admission, Initial admission goals, specify skin integrity issue, history of skin integrity issues, Social Services provided, Mental health needs, Behavioral concerns, PASARR Level II recommendations, Social Services goals, Depression screening. R1 is coded for psychotropic medications and antibiotics, but not anticoagulants. R1 was coded as cognitively impaired but specify cognitively impaired status was not completed. Current medication list provided was left blank. Medication list reconciled with resident / representative Indicated yes, but medication list reconciled by was not coded. 2. R2's Face Sheet documented R2 is a [AGE] year-old female, who admitted to the facility on [DATE]. R2 Diagnoses listed on this document are Encephalopathy, Urinary Tract Infection, Chronic Kidney Disease, Type 2 diabetes, unspecified, Type 2 Diabetes Mellitus without complications, essential (Primary) Hypertension, unspecified Atrial Fibrillation, Fibromyalgia, morbid (severe) obesity, Arthropathy, unspecified. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's Extended Care Facility Transfer Record from (local) Hospital dated 02/23/2024 documents in part: Diagnosis: Acute respiratory failure, Cardiac arrest, Urinary tract infection, Acute encephalopathy, Acute on chronic renal insufficiency, dehydration, hyponatremia, metabolic acidosis, type 2 diabetes, hypertension, Atrial fibrillation. She reportedly suffered a cardiac arrest episode from which she underwent AG protocol with resuscitation intubated and transferred to the ICU on the seventh of this month.: Reported history of post arrest atrial fibrillation for which she has been reportedly kept on amiodarone, now on Coreg and apixaban for anticoagulation. R2's Physician order sheet dated 04/02/2024 documents: Amiodarone HCl Oral Tablet 200 MG Give 1 tablet by mouth one time a day for A-Fib. Start date 02/24/2024. R2's Baseline care plan is undated and unsigned by Resident, Representative, or staff completing plan. Documents admitted as 02/23/2024. The following applicable areas were not completed and left blank: Name of resident's representative, Active diagnoses contributing to admission, Initial admission goals, Education needs, Current medication list provided to, Medication list reconciled by, Social Services provided, Social Services goals, Depression screening. Under Medications, R2 should be coded for Black box medications. Under Medical conditions, Resident should be coded as diabetic. 3.R4's Face Sheet documented R4 is a [AGE] year-old male, who admitted to the facility on [DATE]. R4's Diagnoses listed on this document are encephalopathy, unspecified, Alzheimer's disease, unspecified atherosclerotic heart disease of native coronary artery without angina pectoris, Urinary Tract Infection, site not specified, Sepsis, unspecified organism, unspecified psychosis not due to a substance or known psychological condition, diverticulosis of small intestine without perforation or abscess without bleeding, benign prostatic hyperplasia with lower urinary tract symptoms, other retention of urine. R4's Physician's order sheet dated 4/02/2024, documents the following orders: Foley catheter care every shift every day and nightshift for Cath care. With a start date of 1/31/2024. Foley Catheter: Change monthly and PRN every day shift starting on the 10th and ending on the 10th every month for Foley Catheter with a start date of 02/10/2024. R4's Baseline Care Plan is Undated and Unsigned by Resident, Representative or staff completing plan. Documents admitted as 01/30/2024. The following applicable areas were not completed and left blank: Name of resident's representative, Advanced Directives /Code Status, Active diagnoses contributing to admission, Initial admission goals, Education needs, Specify cognitively impaired status, Psychotropic medications : Adverse effects, Current medication list provided to, Medication list reconciled by, Specify fall during the last month prior to admission, Specify fall during 2-6 months prior to admission, Social Services provided, Mental health needs, Behavioral concerns, Social Services goals, Depression screening. Urinary continence - R4 is coded as always continent. R4 has indwelling catheter and should be rated as not rated. 4. R6's face sheet documented R6 is a [AGE] year-old male, who admitted to the facility on [DATE]. R4's Diagnoses listed on this document in their entirety, Rhabdomyolysis, Traumatic Ischemia of the muscle, subsequent encounter, essential primary hypertension, pain in right knee, pain in left, other chronic pain, benign prostatic hyperplasia without lower urinary tract, localized edema, bilateral primary osteoarthritis of knee, cellulitis of right lower limb, repeated falls. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's Physician order sheet documents dated 04/02/2024 documents active orders with a start date of 02/22/2024 for Oxygen at 2 liters per minute via nasal cannula at bedtime for sleep apnea, Oxygen at 2 Liters per minute per nasal cannula as needed for Shortness of Breath. R6's Baseline Care Plan is undated and unsigned by Resident, Representative, or staff completing plan. Documents admitted as 02/22/2024. The following applicable areas were not completed and left blank: Active diagnoses contributing to admission, Initial admission goals, Education needs, Current medication list provided to, Medication list reconciled by, specify fall during the last month prior to admission, specify fall during 2-6 months prior to admission, Current skin integrity issues, Social Services provided, Mental health needs, Behavioral concerns, Social Services goals, Depression screening. R6's Initial discharge goals are coded as, Return to the community. But Discharge plan initiated was left blank. Special Treatments, Procedures, and Programs is not coded for oxygen therapy. On 03/28/2024 at 2:52pm an attempt was made to review any facilities policy related to care plans, V1 (Administrator) stated the facility follows RAI (Resident Assessment Instrument) guidelines. We do not have any specific guidelines. On 04/02/2024 at 1:36pm, V9 (Regional Director Clinical Reimbursement) stated it is his expectation that all baseline care plans be completed in their entirety. V9 also stated that he was aware that they have issues with Care Plans not being completed timely

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review, the facility failed to develop and implement comprehensive care plans for 4 of 4 residents (R1, R2, R4, R6) reviewed for care plans in a sample of 6. Findings include: 1. R1's Face Sheet documented R1 is a [AGE] year-old female, who admitted to the facility on [DATE]. R1 was discharged on [DATE], after being sent to (Local hospital) emergency roiagnom on [DATE]. Diagnoses listed on this document are Sepsis, unspecified organism, Urinary Tract Infection, site unspecified, bipolar disorder, unspecified, unspecified intellectual disability, unspecified glaucoma. V13 (Physician) is listed as being R1's Primary Care Physician. The only emergency contact listed for R1 on this document is V30 (Guardian/Emergency Contact # 1). On 03/25/2024 during a review of R1's Electronic Medical Record the following were noted: An undated baseline admission care plan, a Minimum Data Set (MDS) with a completion date of 02/27/2024 were present. A Comprehensive Care Plan had not yet been initiated for R1 as of 9:50am on 03/25/2024. On 03/26/2024 it was noted in R1's Electronic Health Record that V9 (Regional Director Clinical Reimbursement) initiated a comprehensive care plan for R1 on 3/25/24. R1's Comprehensive Care Plan dated 03/25/2024 documents Resident Care Information with appropriate interventions of: The resident has a behavior problem related to bipolar disorder. SKIN: At risk for skin complications related to unstageable L buttock injury; self-inflicted scratches to mid-chest; and stage 2 pressure injury to L heel. The resident has bladder incontinence related to History of UTI, Impaired Mobility, Inability to communicate needs. Activities of Daily living: Resident requires assist with daily care needs related to intellectual disability. Resident is receiving (Ibuprofen, Clonazepam, Eliquis) which has a black box warning. On 03/26/2024 at 1:51pm V14(Certified Nurse's Assistant) stated she had taken care of R1 a couple of times. V14 reported that R1 had skin issues. Initially it was just R1's left upper arm, but about a week ago she was scratching and scratching and made a huge sore on her chest. V14 stated that she notified the nurse, she put cream on R1, but she continued to scratch. V14 noticed the circular area on R1's arm but was told it was a scar from a wound she arrived with. V14 stated that she would get R1 out of bed and into her chair frequently, but that R1 had difficulty in chair and would continue to slide down in chair. V14 asked therapy to evaluate R1 for a chair cushion that would help keep R1 in position in chair. V14 stated R1 often stayed in bed because most staff would not get her up due to her inability to stay sitting upright in chair. Denies having showered R1, V14 stated that she was never scheduled for a shower on her days providing care for R1. V14 denies being informed of any behaviors, stated communication is not great around here. She said that R1 did not say much, she cursed a lot and would ask for tea or soda, but that was about it. She denies having had to care for any residents with restraints. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/2024 at 2:05pm V12 (Licensed Practical Nurse) stated she called V13 (Physician) on the day staff alerted her about R1 scratching area on chest, denies it being there prior to that day. V12 stated that she told V13 they did not have the mittens and that they could put some no-show socks over her hands. V12 stated that V13 did not respond to her statement about not having mittens and hung up on her. V13 stated that she went and found the softest pair of no-show socks for R1's hands and she stopped itching. V12 stated that V19 (LPN/Medical Doctor's office) called back with treatment order for the open area to R1's chest. V12 stated that R1 would remove dressing but that they would continue to replace it. Denies having been informed of R1's previous self-injurious behaviors. An email was received by this surveyor on 3/26/2024 from V30 (Guardian). V30 denied any invitation to any meetings related to the care of and care plan development of R1. On 03/26/2024 at 2:17pm V13 (Physician) stated he has been involved in R1's care for years, he was her medical provider at previous facility she lived at for many years. V13 confirmed that R1 did have a history of self-injurious behavior including, scratching, picking and occasionally biting. R13 states that R1 was severely cognitively impaired and has had a severe physical decline over the past year and prognosis has not been great. V13 recalls being notified about new area to chest from R1 scratching and that he had advised the facility to use mittens as they have used in the past with R1 at her previous residence. V13 denies being informed that the facility did not have mittens or that they were using socks instead. V13 stated that there was no follow-up at all after initial phone call on 03/17/2024. R13 commented that he was not being critical of anyone's care, but he understood the complexities of caring for R1. That R1's behaviors made it difficult to provide care for her at times, but none the less, staff knows the importance of notifying R13 of new and changing skin conditions. On 03/28/2024 at 2:52pm an attempt was made to review any facilities policy related to care plans, V1 stated the facility follows RAI (Resident Assessment Instrument) guidelines. We do not have any specific guidelines. 2. R2's Face Sheet documented R2 is a [AGE] year-old female, who admitted to the facility on [DATE]. R2 Diagnoses listed on this document in their entirety are Encephalopathy, Urinary Tract Infection, Chronic Kidney Disease, Type 2 diabetes, unspecified, Type 2 Diabetes Mellitus without complications, essential (Primary) Hypertension, unspecified Atrial Fibrillation, Fibromyalgia, morbid (severe) obesity, Arthropathy, unspecified. R2's Extended Care Facility Transfer Record from (local) Hospital dated 02/23/2024 documents in part: A review of R2's Minimum Data Set, dated dated dated [DATE] documents that R2 is at risk of developing pressure ulcers/injuries. R2 is coded under skin conditions as having a Pressure reducing device for chair and Pressure reducing device for bed. R2 was observed in her room on 03/25/2024 and 04/02/2024 with a pressure reducing mattress and pressure reducing cushion for chair in place. R2's Admission care plan dated 03/13/2024 documents R2 has potential/actual impairment to skin integrity related to pressure injury (stage 2) to L buttock. There are no interventions listed related to Skin integrity for Pressure relieving devices, turn and repositioning or Incontinence care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R4's Face Sheet documented R4 is a [AGE] year-old male, who admitted to the facility on [DATE]. R4's Diagnoses listed on this document in their entirety are encephalopathy, unspecified, Alzheimer's disease, unspecified atherosclerotic heart disease of native coronary artery without angina pectoris, Urinary Tract Infection, site not specified, Sepsis, unspecified organism, unspecified psychosis not due to a substance or known psychological condition, diverticulosis of small intestine without perforation or abscess without bleeding, benign prostatic hyperplasia with lower urinary tract symptoms, other retention of urine. R4's MDS (Minimum Data Set) dated 02/06/2024, documents a BIMS score of 3, indicating that R4 is severely cognitively impaired. R4's MDS Section H- Bladder and Bowel Question H0100. Appliances, documents that R4 has an indwelling catheter. R4's Comprehensive Care Plan documents Resident Care Information initiated 02/06/2024 and include the following: R4 is at risk for falls r/t (related to) Confusion, Psychoactive drug use (Seroquel), Unaware of safety needs, with appropriate interventions. The following Resident Care areas were initiated on 03/25/2024 and were incomplete, with no interventions in place: limited physical mobility r/t, no discharge potential r/t (specify), The resident has Condom/Intermittent/Indwelling Suprapubic) Catheter, resident has impaired cognitive function/dementia or impaired thought processes r/t, The resident uses psychotropic medications (Specify medications) r/t. 4. R6's face sheet documented R6 is a [AGE] year-old male, who admitted to the facility on [DATE]. R4's Diagnoses listed on this document in their entirety, Rhabdomyolysis, Traumatic Ischemia of the muscle, subsequent encounter, essential primary hypertension, pain in right knee, pain in left, other chronic pain, benign prostatic hyperplasia without lower urinary tract, localized edema, bilateral primary osteoarthritis of knee, cellulitis of right lower limb, repeated falls. R6's Physician's Order Sheet dated 04/02/2024 documents active orders with a start date of 02/22/2024 for Oxygen at 2 liters per minute via nasal cannula at bedtime for sleep apnea, Oxygen at 2 liters per minute per nasal cannula as needed for Shortness of Breath. R6's Care plan initiated on 03/13/2024 documents Resident Care Information: Focus: The resident has potential for pressure ulcer development related to Immobility, (initiated 04/01/2024) There are no interventions listed related to Skin integrity for Pressure relieving devices. (Initiated: 04/01/2024) The resident has bladder incontinence at times related to Physical limitations, the only intervention listed is eating patterns. There are no Resident care areas related to Sleep Apnea, Shortness of Breath or the use of oxygen. On 03/26/2024 at 2:50pm V9 (Regional Director Clinical Reimbursement) stated it is not an expectation for the facility to call a resident's previous facility concerning a resident's history, if they were admitted from a hospital and not facility of residence. Unless a problem would arise. V9 stated the same in regards to residents with intellectual disabilities/developmental disabilities or psychiatric diagnosis. V9 stated he was not aware that R1's comprehensive care plan had not been completed in a timely manner, but when he questioned V5 (LPN/MDS coordinator) about accuracy and timely completion of assigned job duties, she stated that she had an extensive list of residents to complete and just had not gotten to it. V9 stated that he was aware that they have issues with Care Plans not being completed timely. V9 also reported that V5 is fairly new and also works on the floor often. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/2024 a review of facility policy Behavioral Assessment, Intervention and Monitoring; (Dated 2023) Documents in part: Assessment: As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations: a. The resident's usual patterns of cognition, mood and behavior. b. The resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts; The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including a. Onset, duration, intensity and frequency of behavioral symptoms. b. Any precipitating or relevant factors, or environmental triggers (e.g., medication changes, infection, recent transfer from hospital); and c. Appearance and alertness of the resident and related observations. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of practice. The resident and family or representative will be involved in the development and implementation of the care plan. Resident and family involvement or attempts to include the resident and family in care planning and treatment, will be documented. The resident and family/representatives will be informed of the resident's condition as well as the potential risks and benefits or proposed interventions. The resident and/or resident surrogate will have the right to refuse treatment. If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function. New or emergent symptoms will be documented and reported. Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment. If any devices (restraints) are prescribed, the IDT will monitor the situation to ensure that they are beneficial to the individual (for example, enhancing function and improving symptoms) and are not causing complications or disabling the individual. a. This will be done frequently when such devices are first employed and regularly thereafter for as long as they are used. b. Over time, the staff will reduce the use or remove such devices or will document why such attempts are not feasible.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44492 Based on interview and record review, the facility failed to assess and seek timely treatment for a self-inflicted injury for 1 (R1) of 3 residents reviewed for skin impairment in a sample of 6. The findings include: R1's Face Sheet documents that R1 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Unspecified and Unspecified Intellectual Disabilities. R1's Face Sheet documents a discharge date from the facility of 3/25/24. R1's Minimum Data Set (MDS) dated [DATE] documents Section C, a Brief Interview for Mental Status (BIMS) score of 13, indicating that R1 is cognitively intact. Section GG, Functional Abilities and Goals, of the same MDS documents that R1 is dependent with all activities of daily living. R1's hospital notes discharge summary dated 2/20/2024, and prior to R1's admission to the facility, under Physical Exam documents in part .There was a circumferential sore on the left forearm, believed to be related to ischemia from a bracelet; No other sores or rashes noted. R1's Initial Admission Weekly Skin Monitoring Record dated 2/20/2024 documents in part .discoloration noted to bilateral upper extremities related to hospitalization .scabbed area noted to circumference to left forearm .scabbed areas noted to second and third toe on right foot .discolored area noted to top of right foot, coccyx intact, right heel intact, wound to left heel (3.5 x 3.5 x 0.1), hospital treatment order in place, small scabbed area to left buttock noted. R1 has no weekly skin monitoring record for the week of 2/28/2024. R1's Weekly Skin monitoring record dated 3/06/2024 documents .excoriated area to back upper left forearm that is covered with dry dressing . R1's Weekly Skin monitoring record dated 3/13/2024 documents in part .weekly skin check completed .R1 has area of dry skin to the back of her left upper arm . R1's Weekly Skin monitoring record dated 3/20/2024 documents in part .(R1) has an area of skin on her chest with self-inflicted scratches that she has rubbed that is raw looking .Orders from (V13-primary physician) are to cover with antibiotic ointment and cover with dry dressing .(R1) continues to rub the dressing off repeatedly .(R1) has an area of dry skin to the back of her left upper arm. R1's care plan dated 03/25/2024 (date of R1's discharge from the facility per Face Sheet) documents the following: Focus: Skin: At risk for skin complications r/t (related to) unstageable L buttock injury; self-inflicted scratches to mid-chest; and stage 2 pressure injury to L (left) heel. Goal: Will remain free of further skin complications throughout next review. Documented interventions include in part: 3/20/2024- Cleanse area, cover with thin layer of antibiotic ointment. Cover with dry dressing. Change daily area to mid-chest; Provide skin care after each incontinent episode; Skin assessment weekly; and Use lift sheet to move patient. (continued on next page)

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	146006	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Anna	315 South Brady Mill Road Anna, IL 62906

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/2024, at 3:35 PM, V7 (CNA) stated that two weeks after R1 got admitted , she noticed her scratching her stomach, chest, and arms. V7 stated that she reported it to V12 (LPN) and was told we are going to monitor her scratching. On 3/26/2024, at 10:20 AM, V10 (CNA) stated that when R1 was admitted she noticed little sores all over her body. V10 stated that R1 would have repetitive scratching to different areas on her body and had to be redirected multiple times. V10 stated that remembers R1 having a discolored area to her left lower arm but it was not open. On 3/27/2024, at 8:20 AM, V20 (CNA) stated that she recalls R1 scratching her upper arms first about a week after she got admitted and reported this to V12 (Licensed Practical Nurse/LPN). On 3/26/2024, at 10:40 AM, V11 (Certified Nurse Aide/CNA), stated that she remembers seeing multiple scratch marks to R1's chest area about a week ago. V11 stated that it looked like she just dug into her chest. V11 stated that she recalls R1 having a soft sock placed over her hand to help keep her from scratching. V11 stated that remembers seeing an area to her left lower arm, that looked old, not open though. On 3/26/2024, at 1:51 PM, V14 (CNA) stated that she had taken care of R1 a couple of times, has not worked at facility the whole time R1 was here. V14 reported that R1 had skin issues. Initially it was just R1's left upper arm, but about a week ago she was scratching and scratching and made a huge sore on noticed the circular area on her arm, but was told it was a scar from a wound she arrived with. On 3/27/2024, at 3:45 PM, V16 (CNA) stated that R1 would scratch herself with her left hand and soft socks were placed over her hands to help keep her from scratching herself. V16 stated that she reported R1's scratching herself to V12 (LPN) and that V12 put some cream to her scratches. On 3/27/2024, at 2:15 PM, V8 (CNA) stated that she helped assist to give R1 a shower on 3/17/2024 and noticed R1 had multiple scratches to her upper chest and it was reported to V12 (LPN). V8 stated that a fuzzy, soft sock was placed on her left hand to help keep her from scratching. On 3/26/2024, at 2:17 PM, V13 (Primary Physician) stated that he has been involved in R1's care for years, he was her medical provider at her previous facility she lived at for many years. V13 confirmed that R1 did have a history of self- injurious behavior including, scratching, picking and occasionally biting. V13 states that R1 was severely cognitively impaired and has had a severe physical decline over the past year and prognosis has not been great. V13 recalls R1 came into this facility with a circular pressure sore to left forearm and a stage III pressure ulcer to her left heel. V13 recalls being notified about a new area to chest from R1 scratching and that he had advised the facility to use mittens as they have used in the past with R1 at her previous residence. V13 denies being informed that the facility did not have mittens or that they were using socks instead. V13 stated that there was no follow-up at all after his initial phone call on 3/17/2024. (continued on next page)

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	146006	A. Building B. Wing	04/04/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/2024, at 10:01 AM, V19 (LPN at primary physician's office), denies having called the facility to give order for R1. V19 stated that she does not personally recall conversation with V12 regarding R1, but receives several calls of this nature from multiple Long Term Care facilities on a daily basis. V19 stated that this facility has a standing order in place for abrasions, which includes the use of Triple Antibiotic Ointment and a bandage or dry dressing. V19 stated that if she was told that R1 had an abrasion, she would have advised them to use standing orders in place for such condition. On 3/27/2024, at 2:05 PM, V12 (LPN) stated that she recalls R1 having a grooved, scabbed area to her left forearm when she got admitted . V12 stated that it was reported to her on 3/17/2024, that R1 had scratched her chest area. V12 stated that when she assessed her, she noticed R1 had dug into her chest hard. V12 stated that she notified V13 (primary physician) about R1's scratches to her chest. V12 stated that V13 told her that this was a long time behavior of R1 and that her previous facility used mittens to cover her hands to keep her from scratching herself. V12 stated that she told him that mittens are not available at the facility. V12 stated that after she told him that, V13 hung up on her. V12 stated that she found soft, no-show socks and placed them on R1's left hand. V12 stated that R1 would rub her hand against her to remove the sock and continue to scratch herself. V12 stated that R1 was monitored and an order was received on 3/19/2024 to apply antibiotic ointment to chest area and cover with a dry dressing. V12 stated that R1 would remove the dressing. V12 stated that she would replace it with another one. R1's progress notes dated 3/16/2024, 9:55 PM, by V32 (LPN) documents in part .R1 has been scratching self to chest, stomach, arms. R1's skin monitoring: comprehensive shower review sheet dated 3/17/2024 documents self-inflicted scratches covering chest area and right antecubital area and documents that V12 (LPN) was notified and the document was signed by V12. R1's progress notes dated 3/17/2024, 2:44 PM, by V12 documents (R1) noted scratching her chest. Area cleansed and cream added. (R1) went right back to scratching the area. Called (V13 Primary Physician) and he said she wore mittens at her (previous) facility. No mittens available. R1 was placed in non-latex gloves and could no longer scratch area. R1's progress notes dated 3/19/2024, 1:35 PM, by V12 documents in part .(R1) has self-inflicted scratches to middle chest. R1's Physician's Orders document an order dated 3/19/2024, 2:54 PM, of cleanse area, cover with thin layer of antibiotic ointment; cover with dry dressing; change dressing daily, every day shift for area to mid chest. R1's Treatment Administration Record (TAR) for March 2024 documents treatment to chest area completed on 3/19/2024 and 3/20/2024. There was no documentation of a treatment order to the chest area documented on the TAR prior to 3/19/24. R1's progress notes dated 3/21/2024, 9:17 AM, documents that R1 is being transferred to local hospital via ambulance. (continued on next page)

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	146006	A. Building B. Wing	04/04/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's hospital notes dated 3/21/2024 documents in part .Presents to emergency department with complaints of low oxygen .(R1) also has several skin wounds and ulcerations from chronic staph infections .(R1) also has cellulitis and possible aspiration pneumonia .started on intravenous antibiotics .been accepted to another higher level of care hospital and being transferred .Diagnosis - Cellulitis of chest wall. The facility's Decubitis Care/ Pressure Area policy (review date January 2014) documents under Procedure Upon identification of skin breakdown the following will be completed; .3) Notify the physician for treatment orders. The physician's orders may include: i) Type of treatment. ii) Frequency the treatment is to be performed. iii) How to cleanse, if needed. iv) site of application . The facility's Change in a Resident's Condition or Status policy (review date 2022) documents under the section titled Policy Interpretation and Implementation in part that 1. The Nurse Supervisor/ Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: a. An accident or incident involving the resident .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44492 Based on interview and record review, the facility failed to identify, assess, and implement treatment and interventions for pressure ulcers for 2 (R1, R2) of 3 residents reviewed for pressure ulcers in a sample of 6. This failure resulted in R1 developing a stage III pressure ulcer area to her left buttock. The findings include: 1. R1's Face Sheet documents that R1 was admitted to the facility on [DATE] with diagnoses of Sepsis, Unspecified Organism, Urinary Tract Infection, Site not specified, Bipolar Disorder, Unspecified, Unspecified Intellectual Disabilities, Unspecified Glaucoma, Acute Embolism, and thrombosis of superior vena cava. R1's Face Sheet documents a discharge date from the facility on 3/25/24. R1's Minimum Data Set (MDS) dated [DATE] documents in Section C, a Brief Interview for Mental Status (BIMS) score of 13, indicating that R1 is cognitively intact. Section GG, Functional Abilities and Goals, of the same MDS documents that R1 is dependent with all activities of daily living. R1's hospital notes discharge summary dated 2/20/2024, under Physical Exam documents in part . There was a 2-centimeter (cm) stage III sore on the left heel; No other sores or rashes noted. R1's Physician's Orders dated 2/20/2024 documents weekly skin check every day shift, every Wednesday. R1's Admission Braden assessment dated [DATE] documents score of 10. A score of 12 or less indicates a High Risk for skin breakdown. R1's Initial Skin Alteration Record (Admission) dated 2/20/2024 documents in part . small, scabbed area to left buttock noted. There were no measurements or location of the wound on the left buttock noted on this initial admission skin assessment. On 3/28/2024, at 11:15 AM, V2 (Director of Nursing) stated that she completed R1's initial skin assessment on admission and noted a scabbed area to left buttock, the size of a small eraser. V2 stated that no measurements were taken of scabbed area to left buttock and no treatment was obtained for scabbed area to left buttock upon admission assessment. V2 stated that R1 developed another area to her inner buttock that was first identified on 3/03/2024, and an order for a dry dressing to her left buttock area was obtained and R1 saw V13 (primary physician) on 3/5/2024 and he referred R1 to the local wound clinic. V2 stated that it is her expectation of the nursing staff to complete weekly skin checks as ordered, initiate a skin alteration record for all new wound areas, and notify the physician to obtain any new treatments. R1's Treatment Administration Record (TAR) for February 2024 documents weekly skin check not being completed for 2/28/2024. There was no Braden assessment noted in R1's Electronic Health Record or provided for review upon request for the week of 2/28/2024. (continued on next page)

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	146006	A. Building B. Wing	04/04/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's TAR for February and March 2024 documents left heel wound, cleanse with normal saline and apply topical ointment with moist dressing and wrap with another dressing every day shift with a start date of 2/21/2024. R1's TAR for 2/25/2024 and 2/28/2024 does not document the treatment as being completed. R1's Skin Monitoring: Shower Sheets dated 2/23/2024 documents an area to left heel (nurse aware); 2/29/2024 documents an area to left heel; 3/01/2024 documents an area to left heel; 3/7/2024 documents an area to left buttock, left heel (nurse notified); 3/14/2024 documents an area to left buttock and left heel; 3/17/2024 documents self-inflicted scratches to chest area, an area to left buttock and left heel; 3/19/2024 documents self-inflicted scratches to chest, and area to left buttock and left heel. R1's TAR for March 2024 documents cleanse wound to left heel, apply foam dressing, wrap with dry dressing, every day shift with a start date of 3/07/2024 and a discontinued date of 3/19/2024. R1's Progress Notes dated 3/01/2024, at 10:39 AM by V12 (Licensed Practical Nurse/LPN) documents in part . Wound to left buttock dry dressing applied. R1's Progress Notes dated 3/03/2024 at 2:28 PM by V12 documents During personal care, 3.5 centimeters (cm) x 4.5 cm area with eschar found on left buttocks; V13 (primary physician) notified; orders to cover area with dry dressing and change daily. R1's TAR for March 2024 documents Place dry dressing on open area to left buttocks daily with a start date of 3/04/2024, 7:00 AM. On 3/26/2024, at 10:20 AM, V10 (CNA) stated that when R1 was admitted she noticed little sores all over her body. V10 stated that she remembers R1 having an open area to her buttock and reported to it to V12 (LPN). On 3/26/2024, at 10:45 AM, V12 (LPN) stated that she reported to V13 (primary physician) on 3/03/2024 that R1 had an area to her left buttock and he ordered a dry dressing and referred her to the wound clinic. V12 stated that R1 went out to the wound clinic on 3/12/2024 and saw V31 (wound physician) and came back with new orders. V12 stated that she updated V30 (guardian) about this area. R1's physician's notes dated 3/05/2024 at 5:30 PM by V13 documents in part . pressure sores to left buttock . left buttock acquired since admission .4 centimeter (cm) soft eschar left buttock . refer to wound clinic for left buttock. R1's Weekly Skin Alteration Record dated 3/06/2024 documents left gluteal fold, 4 cm x 3 cm, open area with eschar); Type of Wound: Pressure, wound margins/edges document irregular, erythema; Peri-Wound area intact; Healing process: new wound; Comments: R1 will see local wound physician at local wound clinic. R1's Braden assessment dated [DATE] documents a score of 11, indicating that R1 is a high risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Wound notes dated 3/12/2024 by V31 (wound physician) documents in part .Pt (patient) presents for evaluation of left buttock pressure ulcer. The wound note documents a location of left buttock unstageable pressure ulcer and documents measurements of 3.7cm x 4.5cm. Post debridement measurements are documented as 3.7 cm x 4.5 cm x 5 mm (millimeters) full thickness to adipose tissue. Under the Assessment/ Plan it documents in part .eschar and nonviable tissue was debrided from the wound . Under the section Plan it documents wash wound daily with soap and water; pack with polymen silver; secure with 4 x 4 and medipore tape; will call with culture results; follow up in one week. R1's Weekly Skin Alteration Record dated 3/13/2024 documents in part . Weekly skin check completed . R1 has a red area to back of left foot with daily treatment . R1 has a discolored area to back of left foot . R1 has an unstageable area of 3.7cm x 4.5cm to left lower buttock . R1 is seeing local wound clinic for these wounds. No measurements noted for left heel for weekly skin alteration dated 3/13/2024. R1's Braden assessment dated [DATE] documents score of 11, indicating that R1 is a high risk for skin breakdown. R1's Wound notes dated 3/19/2024 by V31 (wound physician) documents Pt (patient) presents for follow up of stage III left buttock pressure injury and new left heel ulcer stage II. Wound #1 is documented as a left buttock unstageable pressure ulcer with measurements of 4.0 cm x 3.9 cm x 6 mm. Wound #2 is documented with a location of left heel with measurements of 2 cm x 2 cm x 1 mm. Under Assessment/Plan it documents in part .last visits cultures revealed proteus mirabilis in the wound. A topical compound was prescribed . Under the section Plan it documents the following: wash wound daily with soap and water, apply wet to dry dressing BID (twice a day) to both wounds until the compound topical antibiotic arrives, secure with 4 x4 and medipore tape, when topical compound arrives, stop wt to dry, apply topical compound antibiotic as prescribed, secure with telfa and medipore tape, turn q (every) 2 hours, do not apply direct pressure to wounds, increase protein intake, follow up in 1 week, watch for signs of infection, fever, chills, redness, excessive or foul drainage, increase in pain. There was no order documented in the Electronic Health Record of R1's protein intake being increased as recommended on the wound notes by V31. R1's Weekly Skin Alteration Record dated 3/20/2024 documents in part .Weekly skin completed .R1 has an area to the back of the left foot that has opened up .See TAR for new order from wound doctor .R1 has a discolored area to back of left heel .R1 has unstageable pressure area of 3.7cm x 4.5cm to left lower buttock . R1 is seeing wound clinic for these wounds .New treatment orders on TAR. R1's hospital notes dated 3/21/2024 under Assessment documents in part . R1 has dressing to top of left foot, dressing to left buttock, dressing to right upper arm, scab to the back of neck, rash like area to center of chest and what appears to be an old ligature/scabbed area to left forearm; All areas are old and scabbed. There was no documentation of a wound to the left heel. On 3/26/2024, at 2:17 PM, V13 (Primary Physician) stated that he has been involved in R1's care for years, he was her medical provider at her previous facility she lived at for many years. V13 states that R1 is severely, cognitively impaired and has had a severe physical decline over the past year and prognosis has not been great. V13 recalls being informed of open area to left buttock on 3/03/2024 and giving treatment orders for it. V13 stated that R1 was being followed by an outside wound clinic for area to left buttock. V13 commented that the staff know the importance of notifying V13 of any new and changing skin conditions. (continued on next page)

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	146006	A. Building B. Wing	04/04/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/27/2024, at 8:45 AM, V29 (LPN) stated that he works for this facility and also the previous facility that R1 was at. V29 stated that back in January 2024, R1 lost mobility of her right side. V29 stated that R1 would not cooperate fully but it is possible she had a stroke. V29 stated that he remembers R1 having an open area to her left heel and left buttock. V29 stated that she had a treatment for both and those treatments were done on day shift. On 4/01/2024, at 9:35 AM, V31 (wound physician) stated that he saw R1 in the clinic on 3/19/2024 for a follow-up to her stage III left buttock pressure ulcer and for her stage II left heel pressure ulcer. V31 stated that R1 was not a mobile resident and would need to be turned and repositioned on a regular schedule at least every two hours. V31 stated that it does not take a long time to develop a pressure area, could be less than two hours if not consistently turned and repositioned. On 4/01/2024, at 1:45 PM, V31 (wound physician) stated that he was only made aware of R1's left buttock wound when she first came to the clinic on 3/12/2024. V31 stated that they did not do a whole-body assessment on R1 that day. V31 stated the skin assessment was a focused skin assessment on just the left buttock. V31 stated that he saw R1 again on 3/19/2024 and the left heel area had been added to that appointment. V31 stated that only those two areas were the ones assessed for the 3/19/2024 appointment. On 4/01/2024, at 1:50 PM, V13 (primary physician) stated that he was not made aware of a scabbed area to the left buttock when R1 was admitted on [DATE] and no treatment was ordered at that time. V13 stated that he came to see R1 on 3/05/2024 and assessed her left buttock that showed dry eschar, not particularly affecting her general health. V13 stated that he referred R1 to the wound clinic so it could be debrided. V13 stated that he did not refer R1 to the wound clinic for her left heel wound. V13 stated that her left heel had good, granulating tissue and did not feel she needed to be referred to the wound clinic at that time. R1's Baseline Care Plan, dated 2/22/24, documents no wounds or interventions to prevent skin breakdown. R1 was sent to the hospital on 3/21/2024 with no interventions for pressure ulcers or to prevent skin breakdown in place. R1's Comprehensive Care Plan was not initiated until 3/25/2024. 2. R2's Face sheet documents admitted to the facility on [DATE] with diagnoses of Encephalopathy, Urinary Tract Infection, Chronic Kidney Disease, Type 2 diabetes, unspecified, Type 2 Diabetes Mellitus without complications, essential (Primary) Hypertension, unspecified Atrial Fibrillation, Fibromyalgia, morbid (severe) obesity, Arthropathy, unspecified. R2's Minimum Data Set (MDS) dated [DATE] documents Section C, documents a Brief Interview for Mental Status (BIMS) score of 13, indicating that R2 is cognitively intact. Section GG, Functional Abilities and Goals, documents that R2 requires setup or clean-up assistance with eating, supervision or touching assistance with oral hygiene, dependent with toileting hygiene, showering, upper/lower body dressing, putting on/off footwear, personal hygiene, bed mobility and transfers. R2's Treatment Admission Record documents the following orders related to wound care: Silvadene External Cream 1 % (Silver Sulfadiazine)(SSD) Apply to left buttock topically every day shift for wound apply SSD, collagen powder, calcium alginate pad, and dry dressing daily and as needed. -Start Date 3/13/2024 0700 (7:00 AM); Weekly Skin Check on Friday 7A-7P every day shift every Fri for skin integrity. -Start Date 3/08/2024 0700 (7:00 AM); Weekly Skin Check on Mondays 7A-7P every day shift every Monday for skin integrity. Start Date 2/26/2024 0700 -D/C (discontinue) Date 3/06/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's Baseline Care Plan, dated 2/23/24, under Functional Abilities and Goals-Mobility Substantial/ maximal assistance is marked for roll left to right, sit to lying, lying to sitting in the side of the bed, sit to stand, chair/ bed-to-chair transfer, toilet transfer, and tub/shower transfer. Under Bowel and Bladder documents that R2 is frequently incontinent of bowel and bladder. Under Skin Risk the boxes for current skin integrity issues and history of skin integrity issues are not marked. R2's Braden assessment dated [DATE] documents score is 16, a score of 15-16 indicates a Low Risk. Under the section Moisture, Occasionally moist: Skin is occasionally moist, requiring and extra linen change once a day is marked. Under the section Friction & Shear, Potential Problem: Moves freely or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair most of the time but occasionally slides down is marked. R2's Initial Skin assessment dated [DATE] documents Skin pink, warm & dry. No redness noted to bony prominences. Multiple discolorations noted to BUE (bilateral upper extremities) r/t (related to) IV (intravenous) & blood draws in hospital. Redness/excoriation noted to bottom/peri-area with barrier cream applied. Dry scaly skin noted to bilateral ankles & feet. Bilateral heels intact. No open areas or areas of concern noted at this time. R2's Care Plan dated 3/13/2024 documents a Focus area of: R2 has potential/actual impairment to skin integrity related to pressure injury (stage 2) to left buttock. Goals: R2 has potential/actual impairment to skin integrity related to pressure injury (stage 2) to left buttock with a target date of 6/11/2024. Interventions: Follow facility protocols for treatment of injury. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to primary physician. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface with a start date of 3/13/2024. On 4/2/2024, at 3:00 PM, V9 (Regional Clinical Reimbursement) stated that if a resident has a pressure relieving mattress or cushion, it should be listed as an intervention in their care plan. R2's Weekly Skin Alteration Record dated 3/13/2024 documents left buttock, small pea size open area with pink wound bed measuring 0.5cm x 0.5cm. On 3/25/2024, at 2:00 PM, R2 stated that they just don't turn you enough here. R2 states that staff are sweet and try their best here, but there just aren't enough people. R2 reports she got in her chair at around 8:00 AM or 9:00 AM and has been in her chair since then. R2 reports that they forgot to put her pressure relieving cushion in her chair. R2 was observed to not have cushion in her chair and the pressure relieving cushion was observed lying on her bed at this time. R2 was observed with the call light around her wrist, she states it is her preference because she needs it and always knows where it is. R2 stated that her bottom hurts at this time, but the incontinence brief she wears does make it worse. On 3/25/2024, at 2:45pm, R2 was observed sitting on edge of chair, restless with expressions of pain. R2 stated that her bottom and legs hurt, and she just wanted to lay down. (continued on next page)

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	146006	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Anna	315 South Brady Mill Road Anna, IL 62906

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/25/2024, at 3:15pm R2 was laid down and wound treatment was observed. V5 (Licensed Practical Nurse) performed wound care with the assistance of V7 (Certified Nurse's Assistant). Left buttock wound has pink wound bed with no drainage noted or signs and symptoms of infection noted. V5 performed treatment as ordered with no concerns of infection control noted. R2 tolerated treatment with no complaints of pain or discomfort noted. The facility's Decubitus/Pressure Area policy dated January 2014 documents under Policy: To ensure a proper treatment has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified; Procedure: Upon identification of skin breakdown, the following will be completed: 1. Pressure area will be assessed and documented; 2. Complete all areas of a wound assessment following National Pressure Ulcer Advisory Panel (NPUAP) guidelines: i) Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician); 4. Documentation of the pressure area must occur upon identification and at least once each week. The facility's Preventative Skin Care policy dated January 2014 documents under Policy: To provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, well-groomed, and free from pressure ulcers; under Procedures: 1. All residents will be assessed using the Braden Pressure Ulcer Scale at the time of admission and weekly x 4, then will be reassessed at least quarterly and/or as needed; 3. After thorough cleaning of the skin, lotion may be applied and observation of any reddened areas will be reported to the Charge Nurse; 5. Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two (2) hours.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44492 Based on interview and record review, the facility failed to implement interventions for self-injurious behaviors and obtain necessary behavioral health services for 1 (R1) of 1 resident reviewed for behavioral health in a sample of 6. This failure resulted in R1 developing cellulitis to a self-inflicted wound to the chest wall. The findings include: R1's Face Sheet documents R1 was admitted to the facility on [DATE] with a diagnosis including Bipolar Disorder, Unspecified, and Unspecified Intellectual Disabilities. R1's Face Sheet documents a discharge date from the facility of 3/25/24. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 13, indicating R1 was cognitively intact. This same MDS documents R1's Functional Abilities and Goals as Dependent with all activities of daily living. R1's baseline care plan, dated 2/22/24, the section Active diagnoses contributing to admission is left blank. There is no documentation of R1's self-injurious behavioral concerns and the Social Services section is left blank. R1's Care Plan dated 3/25/2024 (date of R1's discharge from the facility per Face Sheet) does not document scratching or self-injurious behaviors. On 3/25/2024, at 8:50 AM, V30 (Guardian) stated that she did not visit R1 while she was at the facility. V30 stated that she visited R1 when she was at the emergency roiagnom on [DATE]. V30 stated that she did not disclose any self-injurious behavior to the facility when R1 got admitted to the facility. V30 stated that R1 wore mittens at her previous facility to help keep her from scratching herself. On 3/26/2024, at 10:20 AM, V10 (Certified Nurse Assistant/CNA) stated that when R1 was admitted she noticed little sores all over her body. V10 stated that R1 would have repetitive scratching to different areas on her body and had to be redirected multiple times. V10 denies being informed of R1's chronic self-injurious behaviors. On 3/26/2024, at 10:40 AM, V11 (CNA) stated that she remembers seeing multiple scratch areas to R1's chest like she had dug into her chest. V11 stated that the staff would put socks over her hands to help keep her from scratching. V11 denies being informed of R1's chronic self-injurious behaviors. On 3/27/2024, at 8:20 AM, V20 (CNA) stated that she recalled R1 scratching her upper arms first about a week after she got admitted and reported this to V12 (LPN). (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 3/26/2024, at 2:05 PM, V12 (Licensed Practical Nurse/LPN) stated that it was reported to her on 3/17/2024, that R1 had scratched her chest area. V12 stated that when she assessed her, she noticed R1 had dug into her chest hard. V12 stated that she notified V13 (Primary Physician) about R1's scratches to her chest. V12 stated that V13 told her that this was a long-time behavior of R1 and that her previous facility used mittens to cover her hands to keep her from scratching herself. V12 stated that she told him that mittens are not available at the facility. V12 stated that after she told him that, V13 hung up on her. V12 stated that she found soft, no-show socks and placed them on R1's left hand. V12 stated that R1 would rub her hand against her to remove the sock and continue to scratch herself. On 3/26/2024, at 2:17 PM, V13 (Primary Physician) stated that he has been involved in R1's care for years and was her medical provider at the previous facility she lived at for many years. V13 confirmed that R1 did have a history of self-injurious behavior including, scratching, picking and occasionally biting. V13 states that R1 was severely cognitively impaired and has had a severe physical decline over the past year and prognosis has not been great. V13 recalls being notified about new area to chest from R1 scratching and that he had advised the facility to use mittens as they have used in the past with R1 at her previous residence. V13 denied being informed that the facility did not have mittens or that they were using socks instead. On 3/26/2024, at 2:50 PM, V9 (Regional Director Clinical Reimbursement) stated that it is not an expectation for the facility to call a resident's previous facility concerning a resident's history, if they were admitted from a hospital and not a facility of residence. Unless a problem would arise, V9 stated the same regarding residents with intellectual disabilities/developmental disabilities or psychiatric diagnosis. On 3/27/2024, at 8:45 AM, V29 (LPN) stated that he works for this facility as well as the previous facility where R1 resided. V29 stated that R1 has a chronic behavior of scratching herself. V29 stated that at her previous facility, they would put mittens over her hands to keep her from scratching. V29 stated that it would not be uncommon for R1 to rub a spot open in two hours, it would happen so quickly at times. V29 stated that he works mainly at night at this facility and while he worked R1 was usually in bed, calm and quiet. On 3/27/2024, at 2:15 PM, V8 (CNA) stated that R1 scratched herself hard one day in the upper chest area. V8 stated that soft, fuzzy socks were placed over her hands to help to keep her from scratching self. On 3/27/2024, at 3:35 PM, V7 (CNA) stated that two weeks after R1 got admitted , she noticed her scratching her stomach, chest, and arms. V7 stated that she reported it to V12 (LPN) and was told they were going to monitor her scratching. On 3/27/2024, at 3:45 PM, V16 (CNA) stated that R1 would scratch herself with her left hand and soft socks were placed over her hands to help keep her from scratching herself. V16 stated that she reported R1's scratching herself to V12 (LPN) and that V12 applied some cream to her scratches. On 4/2/2024, at 10:45 AM, V2 (Director of Nursing/DON) stated that she did not receive any information about R1's medical or psychosocial history from V30 (Guardian). V2 stated that she spoke with a staff from her previous facility when she came to visit R1 but did not ask about her previous history at that time. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	R1's progress notes dated 3/16/2024 at 9:55 PM and written by V32 (LPN) documents in part . R1 has been scratching self to chest, stomach, arms. R1's progress notes dated 3/17/2024 at 2:44 PM and written by V12 (LPN) documents (R1) noted scratching her chest. Area cleansed and cream added. R1 went right back to scratching the area. Called (V13 Primary Physician) and he said she wore mittens at her facility. No mittens available. (R1) was placed in non-latex gloves and could no longer scratch area. R1's progress notes dated 3/19/2024 at 1:35 PM and written by V12 (LPN) documents in part .(R1) has self-inflicted scratches to middle chest. R1's hospital notes dated 3/21/2024 documents in part . Presents to emergency department with complaints of low oxygen .(R1) also has several skin wounds and ulcerations from chronic staph infections .(R1) also has cellulitis and possible aspiration pneumonia . started on intravenous antibiotics . been accepted to another higher level of care hospital and being transferred . Diagnosis - Cellulitis of chest wall. On 4/3/2024, at 1:25 PM, V1 (Administrator) stated that she spoke with V35 (staff form R1's previous facility) about R1's medical history and V1 stated that V35 told her that R1 did not have any behaviors but that she might curse at you occasionally. V1 stated that she always tries to get the previous history on residents from hospitals or other facilities before they get admitted . V1 stated that it is very important to her to know about any resident's behaviors so a decision can be made if the facility can meet their needs or not. On 4/2/2024, at 3:00 PM, V9 (Regional Director Clinical Reimbursement), stated that he was unaware of the staff placing socks on R1's hands to help prevent her from scratching herself. V9 stated that it is his expectation of the nursing staff to perform an assessment, get a consent from guardian, and obtain a physician's order before ever implementing placing a sock or any other restraint device on a resident. V9 stated that the nursing staff should have obtained an order for mittens when V13 (primary physician) suggested it. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	The facility's Behavioral Assessment, Intervention, and Monitoring policy (revision date December 2016) documents in part under the section Policy Statement, 1. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. Under the section titled Assessment it documents in part 1. As part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, and mental illness (bipolar, schizophrenia). 2. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations: a. The resident's usual patterns of cognition, mood, and behavior; b. The resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts; and c. The resident's typical or past responses to stress, fatigue, fear, anxiety, frustration, and other triggers. 3. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including: a. Onset, duration, intensity, and frequency of behavioral symptoms; b. Any precipitating or relevant factors, or environmental triggers (e.g., medication changes, infection, recent transfer from hospital); and c. Appearance and alertness of the resident and related observations. 4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. Under the section titled Cause & Identification it documents 1. The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition. Under the section titled Management it documents 1. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm 2. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of practice. 3. The resident and family or representative will be involved in the development and implementation of the care plan. Resident and family involvement or attempts to include the resident and family in care planning and treatment, will be documented. 4. The resident and family/representatives will be informed of the resident's condition as well as the potential risks and benefits or proposed interventions .7. Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress or loss of abilities. 8. Interventions and approaches will be based on a detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. Under the section titled Monitoring it documents 1. If the resident is being treated for altered behavior or mood, the IDT (Interdisciplinary Team) will seek and document any improvements or worsening in the individual's behavior, mood, and function. 2. The IDT will monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported. 3. Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment .7. If any devices (restraints) are prescribed, the IDT (Interdisciplinary Team) will monitor the situation to ensure that they are beneficial to the individual (for example, enhancing function and improving symptoms) and are not causing complications or disabling the individual. a. This will be done frequently when such devices are first employed and regularly thereafter for as long as they are used. b. Over time, the staff will reduce the use or remove such devices, or will document why such attempts are not feasible.