

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Integrity Hc of Anna		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356</p> <p>Based on interview and record review, the facility failed to immediately report allegations of abuse to the Administrator for 4 of 13 residents (R14, R15, R16, and R17) reviewed for abuse in a sample of 17.</p> <p>Findings include:</p> <p>On 4/16/24 at 11:40AM, V9 (Certified Nurse Assistant/ CNA) stated that the V11 (Licensed Practical Nurse/LPN) has been rude and yells at R16 and R15. V9 said that R15 will touch other resident food and V11 will tell R15 to get his nasty fingers out of other residents' food. V9 said that V11 will yell at R16 to get away or move out of the way. V9 stated that she did not know who the abuse coordinator was and that she didn't know who to report abuse to. V9 said she wanted the number for public health to report the abuse to, but she said the administrator wouldn't give her the number for public health. V9 said that she wasn't aware of any other staff being verbally or physically abusive to any other resident.</p> <p>On 04/16/24 at 1:00PM, V7 (Certified Nurse Assistant/CNA) stated that V11 (LPN) has pushed R16 away from her when he gets to close. V7 stated that V11 has also slapped R14's hands when he starts grabbing at stuff or puts his hands on her. V7 stated that she has never reported any of this to the administrator. V7 stated that she did not know who the abuse coordinator was at the facility, and she was never trained on who the abuse coordinator was. V7 said she has asked for the number to public health to report the above incidents, but that V1(Administrator) would not give it to her. V7 said she feels like if she reported V11 to the other nurses on duty that they would tell V11 and nothing would get done about it. V7 said she really doesn't work with V11 much, but it's been about 2 weeks ago since the last time she worked with her. V7 said that was the last time she saw V11 being mean with R14 and R16. V7 said they also have another nurse V16 (LPN) who she tried to report that R17 wasn't doing very well to. V7 said that V16 stated that she wasn't going in R17 room to assess him, because he had head lice. V7 said R17 started to code and then V16 finally went into R17's room.</p> <p>R14's Face sheet, dated 04/18/24 document an admitted [DATE], and diagnoses in part as encephalopathy, Alzheimer's disease, and unspecified psychosis not due to substance or known physiological. R14' s Minimum Data Set (MDS) dated [DATE], documents his Brief Interview of Mental Status (BIMS) score of 3, indicating that he has severely impaired cognition. R14' s MDS Section GG documents Toileting hygiene and showers as dependent. Upper and lower body dressing as partial/moderate assistance.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R15's Face Sheet, dated 04/18/24 documents an admitted [DATE], and diagnoses in part as unspecified dementia, schizophrenia, mild intellectual disabilities, cognitive communication deficit, and other recurrent depressive disorders. R15's Minimum Data Set (MDS) dated [DATE] Section C Brief Interview of Mental Status (BIMS) score of 99, indicating severely impaired cognition. R15's Section GG documents oral hygiene and toileting as partial/moderate assistance and showering, upper and lower body dressing as substantial/maximal assistance.</p> <p>R16's Face Sheet, dated 04/18/24 documents an admitted [DATE], and diagnoses in part as diffuse traumatic brain injury without loss of consciousness, depression, anxiety disorder, and seizures. R16's MDS dated [DATE], documents in Section C a Brief Interview of Mental Status (BIMS) score of 10, indicating moderately impaired cognition. R16's Section GG documents toileting, showers, upper and lower body dressing and putting on and taking off shoes as supervision or touch assistance.</p> <p>R17's Face Sheet, dated 04/18/24 documents an admitted [DATE], and diagnoses in part as secondary malignant neoplasm of other specified sites, other disorder of psychological development, personal history of malignant neoplasm of prostate, and personal history of malignant neoplasm of bone. R16's Minimum Data Set (MDS) dated [DATE] document in Section C a Brief Interview of Mental Status (BIMS) score of 99, indicating severely impaired cognition. R16 s Section GG documents dependent for eating, toileting, showering, upper and lower body dressing, and personal hygiene.</p> <p>On 04/17/24 at 12:00PM, V1(Administrator) stated she was not aware of any abuse to any resident until this surveyor reported the allegations that V7 and V9 reported concerning R14, R15, R16, and R17. V1 stated she will start investigations on those allegations.</p> <p>The Facility Abuse Prevention Training Program-Protocol reviewed and updated 2022, documents under Internal Reporting Employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence. Any employee who knows or suspects that abuse has occurred and has not reported the abuse or makes false allegations of abuse will face possible termination. Any employee who knows or suspects that abuse has occurred and makes an immediate report out of a legitimate concern shall not be penalized or reprimanded for making such report.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356</p> <p>Based on interview and record review the facility failed to ensure that residents who require assistance with transfers into bed were assisted in a timely manner for 1 of 1 resident (R1) reviewed for Activities of Daily Living (ADL) in the sample of 17.</p> <p>Findings include:</p> <p>R1's Face Sheet, dated 04/17/24, documents an admitted [DATE] to the facility with diagnoses of Type 2 diabetes mellitus, Hypertension, Chronic Kidney Disease Stage 4, and Arthritis.</p> <p>R1's Minimum Data Set (MDS) dated [DATE], documents in Section C a Brief Interview for Mental Status (BIMS) score of 8, indicating that R1 has moderately impaired cognition. Section GG documents R1 is dependent for transfers, toileting, showers, and personal hygiene.</p> <p>R1's Current Care Plan, documents a focus of Skin at risk for skin complications r/t related to incontinence, potential for friction/shearing and weakness. At increased risk for further skin breakdown due to refusal of pressure relieving boots with intervention of turn and position per facility protocol. At minimum every 2 hours, Focus of Dialysis renal hemodialysis r/t (related to) severe chronic kidney disease, Focus of R1 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) weakness and impaired cognition. R1 is dependent with mobility and self-care task due to the need of 2 staff assist. He is able to feed himself with set-up assistance but may require verbal ques at times. He uses a w/c (wheelchair) for locomotion in which he is propelled by staff, Focus of R1 has a diagnosis of CKD (chronic kidney disease) stage 4 intervention includes plan rest periods as needed.</p> <p>On 04/15/24 at 3:15PM, R1 stated he has had to wait on several occasions to be laid down after getting back from dialysis. R1 stated that he is always so sick and very tired after he gets back from dialysis and just wants to lay down right away. R1 stated that one day last week it took staff a very long time to lay him down because they didn't have enough staff to help lay him down. R1 wasn't sure how long he had to wait, but he knows it took a very long time before they came and laid him down. R1 stated that they could use more staff at nighttime.</p> <p>On 04/17/24 at 8:30AM V5 (Transit Operation Director) stated that R1 was dropped off at the facility from dialysis at 6:23PM on 04/08/24.</p> <p>On 04/15/24 at 2:15PM, V3 (Regional Nurse) and V2 (Director of Nursing/DON) stated that they only had 1 nurse and 1 laundry staff on 04/08/24 until V4 (Care Plan Coordinator Nurse/CPC) came in at around 9:00pm. V3 and V2 stated that another staff member did come in to help V4 on the floor at around 10:00PM. They both stated that they had one certified nurse's assistant call off and the other one showed up but wouldn't clock in because she didn't want to work by herself.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/16/24 at 10:35AM, V4 (Care Plan Coordinator Nurse/CPC) stated that she did come in to work on 04/08/24 when they only had 1 nurse and 1 laundry staff in the building. V4 said that she got to the facility around 9:00PM. V4 stated that all nurses and certified nurse assistance work 12-hour shifts. V4 said on 04/08/24 that 2 certified nurse assistance's were scheduled to work 7:00PM to 7:00AM shift along with one nurse. V4 said that one of the certified nurse assistance's called off on 04/08/24 for the 7:00PM to 7:00AM shift. V4 stated that the other certified nurse assistance showed up and came into the building, but found out the other certified nurse assistance called in so she said that she wasn't clocking in to work unless there were other staff in the building besides her and one nurse. V4 said that since the certified nurse assistant didn't clock in to work it only left one nurse on the floor from 7:00PM until she arrived around 9:00PM on 04/08/24. V4 said that the administrator contacted her, and she came in to work at around 9:00PM. V4 said that they did have another staff member a certified nurse assistant come in around 10:00PM to work on the floor with her. V4 said that R1 was still up when she got to the facility at around 9:00PM and that she had to wait for the other certified nurse assistant to come in before she could put R1 to bed, because R1 was a mechanical lift transfer and she needed assistance with the transfer. V4 said that R1 was not put to bed until after 10:00PM on 04/08/24. V4 said that there was a couple of other residents she had to wait to lay down as well until the other certified nurse assistant came in. V4 said the facility usually has 1 or 2 nurses on the 7:00PM to 7:00PM shift and around 2-6 certified nurse assistants for the 7:00PM to 7:00AM shift every night.</p> <p>On 04/16/24 at 3:00PM, V2 (Director of Nursing/DON) said that she was aware that they only had 1 nurse and 1 laundry person in the building on 04/08/24 for several hours to take care of all the residents. V2 said that V4 came in around 9:00PM on 04/08/24 to work the floor as a CNA. V2 said she had another staff member a certified nurse assistant come in around 10:00PM to also work. V2 said that she has never had this happen before. V2 said night shift is normally 2 certified nurse assistants she would like to have 3-4 certified nurse assistants at nighttime. V2 said that they will normally have 2 nurses on nights as well. V2 said that she has never had just 1 nurse and 1 certified nurse assistant on night shift. V2 stated that she believes that they usually have enough staff on nights shift but that the staff that are working don't provide quality work when they are here. V2 said that she does think they could use some more staff on nights.</p> <p>On 04/17/24 at 12:00PM, V1 (Administrator) said that she was aware that they only had 1 nurse and 1 laundry person in the building on 04/08/24 for several hours from around 7:00PM to 9:00PM. V1 stated at 9:00PM that another nurse came in to work as a certified nurse assistant. V1 said then a certified nurse assistant came in at around 10:00PM to help out as well. V1 said they called her to let her know that one of the certified nurse assistants called off and that the other certified nurse assistants would not clock in because she didn't want to work by herself until they found someone.</p> <p>On 04/17/24 at 1:30PM, V1 stated that they do not have an activities of daily living (ADL) policy because they are just standards of practice.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356</p> <p>Based on interview and record review, the facility failed to ensure sufficient staff were available to meet resident needs. This failure has the potential to affect all 56 residents living in the facility.</p> <p>Findings include:</p> <p>1. On 04/15/24 at 3:15PM, R1 On 04/15/24 at 3:15PM, R1 stated he has had to wait on several occasions to be laid down after getting back from dialysis. R1 stated that he is always so sick and very tired after he gets back from dialysis and just wants to lay down right away. R1 stated that one day last week it took staff a very long time to lay him down because they didn't have enough staff to help lay him down. R1 wasn't sure how long he had to wait, but he knows it took a very long time before they came and laid him down. R1 stated that they could use more staff at nighttime.</p> <p>R1's Face Sheet, dated 04/17/24, documents an admitted [DATE] to the facility with diagnoses of Type 2 diabetes mellitus, Hypertension, Chronic Kidney Disease Stage 4, and Arthritis. R1's Minimum Data Set (MDS) dated [DATE], documents in Section C a Brief Interview for Mental Status (BIMS) score of 8, indicating that R1 has moderately impaired cognition. Section GG documents R1 is dependent for transfers, toileting, showers, and personal hygiene. R1's Care Plan, documents a focus of Skin at risk for skin complications r/t related to incontinence, potential for friction/shearing and weakness. At increased risk for further skin breakdown due to refusal of pressure relieving boots with intervention of turn and position per facility protocol. At minimum every 2 hours, Focus of Dialysis renal hemodialysis r/t (related to) severe chronic kidney disease, Focus of R1 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) weakness and impaired cognition. R1 is dependent with mobility and self-care task due to the need of 2 staff assist.</p> <p>On 04/17/24 at 8:30AM, V5 (Transit Operation Director) stated that R1 was dropped off at the facility from dialysis at 6:23PM on 04/08/24.</p> <p>On 04/15/24 at 2:15PM, V3 (Regional Nurse) and V2 (Director of Nursing/DON) stated that they only had 1 nurse and 1 laundry staff on 04/08/24 until V4 (Care Plan Coordinator/CPC) came in at around 9:00PM. V3 and V2 stated that another staff member did come in to help V4 on the floor at around 10:00PM. They both stated that they had one certified nurse's assistant call off and the other one showed up but wouldn't clock in because she didn't want to work by herself.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/16/24 at 10:35AM, V4 (Care Plan Coordinator Nurse/CPC) stated that she did come in to work on 04/08/24 when they only had 1 nurse and 1 laundry staff in the building. V4 said that she to the facility around 9:00PM. V4 stated that all nurses and certified nurse assistance work 12-hour shifts. V4 said on 04/08/24 that 2 certified nurse assistance's were scheduled to work 7:00PM to 7:00AM shift along with one nurse. V4 said that one of the certified nurse assistance's called off on 04/08/24 for the 7:00PM to 7:00AM shift. V4 stated that the other certified nurse assistance showed up and came into the building, but found out the other certified nurse assistance called in so she said that she wasn't clocking in to work unless there were other staff in the building besides her and one nurse. V4 said that since the certified nurse assistant didn't clock in to work it only left one nurse on the floor from 7:00PM until she arrived around 9:00PM on 04/08/24. V4 said that the administrator contacted her, and she came in to work at around 9:00PM. V4 said that they did have another staff member a certified nurse assistant come in around 10:00PM to work on the floor with her. V4 said that R1 was still up when she got to the facility at around 9:00PM and that she had to wait for the other certified nurse assistant to come in before she could put R1 to bed, because R1 was a mechanical lift transfer and she needed assistance with the transfer. V4 said that R1 was not put to bed until after 10:00PM on 04/08/24. V4 said that there was a couple of other residents she had to wait to lay down as well until the other certified nurse assistant came in. V4 said the facility usually has 1 or 2 nurses on the 7:00PM to 7:00PM shift and around 2-6 certified nurse assistants for the 7:00PM to 7:00AM shift every night.</p> <p>On 04/16/24 at 11:12AM, V13 (Certified Nurse Assistant/CNA) stated that they do have some problems with staffing especially the night shift. V13 said she did work on 04/08/24 when they had only one nurse and a laundry aid working. V13 said that she got off work at around 7:00PM that day. V13 said that one of the certified nurse assistants called in for night shift that night and the other certified nurse assistant wouldn't clock in. V13 said they let her leave because there were 2 certified nurse assistants from day shift still in the building at that time.</p> <p>On 04/15/24 at 11:16AM, R5 who was alert to person, place and time stated she feels like they could use some more help on the night shift. R5 said usually its one nurse and two certified nurse assistants at nighttime.</p> <p>On 04/15/24 at 11:35AM, R7 who was alert to person, place and time stated they don't have a lot of people on the night shift. R7 said that there is only a couple of people here in the building at night.</p> <p>On 04/15/24 at 12:00PM, R9 who was alert to person place and time stated he thinks they need more help in the evening.</p> <p>On 04/16/24 at 11:40AM, V9 (CNA) said that evening shift is usually always where it is short. V9 said she thought there have been only one staff on evening on a couple of occasions. V9 said that when she comes in the morning you can tell they were short.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/16/24 at 3:00PM, V2 (DON) said that she was aware that they only had 1 nurse and 1 laundry person in the building on 04/08/24 for several hours to take care of all the residents. V2 said that V4 came in around 9:00PM on 04/08/24 to work the floor as a CNA. V2 said she had another staff member a certified nurse assistant come in around 10:00PM to also work. V2 said that she has never had this happen before. V2 said night shift is normally 2 certified nurse assistants she would like to have 3-4 certified nurse assistants at nighttime. V2 said that they will normally have 2 nurses on nights as well. V2 said that she has never had just 1 nurse and 1 certified nurse assistant on night shift. V2 stated that she believes that they usually have enough staff on nights shift but that the staff that are working don't provide quality work when they are here. V2 said that she does think they could use some more staff on nights.</p> <p>On 04/17/24 at 12:00PM, V1 said that she was aware that they only had 1 nurse and 1 laundry person in the building on 04/08/24 for several hours from around 7:00PM to 9:00PM. V1 stated at 900PM that another nurse came in to work as a certified nurse assistant. V1 said then a certified nurse assistant came in at around 10:00PM to help out also. V1 said they called her to let her know that one of the certified nurse assistants called off and that the other certified nurse assistants would not clock in because she didn't want to work by herself until they found someone.</p> <p>The Resident Listing Report dated 4/17/24 documents there are 56 residents living in the facility.</p>		