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	02/19/2026

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 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** Based on interviews and record reviews, the facility failed to implement intervention to promote safety and healing of a diabetic ulcer for 1 of 3 residents (R1) reviewed for wounds in a sample of 7. The findings include:R1's admission Record documents an admission date of 1/26/2025 and documents that R1 was discharged to an acute care hospital on 1/22/26. This admission Record documents diagnoses including Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure, Type 2 Diabetes Mellitus, Non-Pressure Chronic Ulcer of other parts of Right Foot with Fat Layer Exposed, Anxiety, Major Depressive Disorder, Lymphedema, Congestive Heart Failure, and Hypothyroidism. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 12 indicating R1 has moderate cognitive impairment. Section GG documents R1 requires Partial/moderate assistance with shower/bathing, Substantial/maximal assistance with rolling left to right to back while in bed, sitting to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, Toilet transfers, and Tub/shower transfers. R1 is dependent on staff for toileting hygiene, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. R1 uses a manual wheelchair for mobility. R1 can wheel 150 feet once seated in wheelchair, the ability to wheel at least 150 feet in a corridor or similar space with supervision or touching assistance. Section M-Skin Conditions documents R1 has a Diabetic Foot Ulcer.R1's Care Plan documents Wound: R1 has a wound to Right plantar foot related to Diabetes Mellitus, dated 6/17/2025 and revision date of 8/5/2025. Goal: wounds will improve each week with wound doctor directions of care until area is resolved dated initiated: 6/17/2025, target date: 1/21/2026. Interventions include Apply treatments to wound as ordered- gauze, sodium hypochlorite solution, and gauze packing strips (iodoform) twice a day dated 8/5/2025 with revision on 2/10/2026. R1 is dependent on staff for Activities of Daily Living (ADL's) and hygiene. R1 is Non-Weight Bearing (NWB) to right lower extremity related to wound. R1 will be told to elevate his leg and at times will refuse. Dated 2/4/2025 and revision of 2/10/2026. R1 will improve current level of function through the review date: date initiated 2/4/2025, revision date of 2/6/2026 and target date of 1/21/2026. Goal: R1 will improve current level of function through the review date, date initiated 2/4/2025, revision on 2/6/2025, and target date of 1/21/2026. Interventions: R1 requires staff assistance with dressing grooming, transfers, ambulation, and hygiene dated 2/5/2025 and revision on 2/4/2025. R1 will maintain NWB status to Right lower extremities dated 2/4/2025 and revision on 2/4/2025. Skin inspection: observe for redness, open areas, scratches, cuts, bruises and report changes to nurse, dated 2/4/2025 and revision date on 2/4/2025. No observations were made of R1 during this survey due to R1 currently being in the hospital.The facility Wound Log dated December 2025 documents R1 has a wound to Right Plantar, type: Diabetic Ulcer, size: 4.5 Centimeter (cm) Length (L), x 2.5 cm width (W) x 4cm Depth (D).R1's Braden Scale assessment for risk of skin breakdown dated 10/14/2026 documents a score of 16, indicating R1 has a low risk for skin breakdown.R1's Wound Evaluation and Management Summary, (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: 146006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Integrity Hc of Anna		STREET ADDRESS, CITY, STATE, ZIP CODE 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	by V9 (Wound Physician) dated 11/5/2025, 11/12/2025, 11/19/2025, and 11/26/2025 all documented an order for a Pressure Relieving Boot for feet. On 2/17/2026 at 9:47AM, V17 (Certified Nursing Assistant/CNA) stated R1 was very noncompliant with wanting to lay down during the day and he did not like keeping his feet elevated. V17 stated R1 always had a dressing on his foot, and it would get dirty sometimes. V17 stated the only time she seen heel protectors was when R1 was in bed but that was a couple of times. V17 stated she never seen R1 with a boot of any kind while he was up in his wheelchair.On 2/17/2026 at 10:02AM, V18 (Family Member) stated R1 was still in the hospital. V18 stated R1 had a wound to his right foot for a very long time. V18 stated it is from his diabetes. V18 stated the diabetes has caused his bones to be brittle over the years and R1 is a big man so they had a specialized boot made for him that he wore at home to prevent any fractures in his foot. V18 stated R1 was Non-Weight Bearing (NWB) on his right foot. V18 stated she brought the boot to the facility and gave it to the administrator when R1 admitted to the facility. V18 stated I never seen the boot or any kind of boot on R1 when I went to visit and I saw him frequently. V18 stated the hospital said that his foot was shattered into tiny bone fragments. V18 stated R1 had a bad infection as well and it spread to his blood, and he eventually had to have his leg amputated above the knee so that they could get the infection taken care of. V18 stated they also had to replace his pacemaker because the leads on the pacemaker became infected as well from the bacteria in his blood that came from his foot. V18 stated at the nursing home R1 would not keep his feet elevated like he should, and he is a hard resident to take care of sometimes. V18 stated she is hoping R1 will return to this nursing home soon because he will be closer to home and it will be easier for her.On 2/17/2026 at 10:20AM V7, (Physical Therapy Assistant/PTA) stated she remembers when R1 was first admitted to the facility, the family brought in a pressure relieving boot, but it did not fit. V7 stated she always had seen R1's foot wrapped but no boot on it. V7 was asked if anyone tried to have R1 fitted for a better fitting boot for pressure relief and V7 stated I am not sure.On 2/17/2026 at 10:26AM, V19 (Registered Nurse/RN) stated R1 was non-compliant at times. V19 stated she had never seen R1 with a boot and he never had an order for any type of boot that she was aware of.On 2/17/2026 at 10:32AM, the process of wound physician notes and orders was discussed with V12 (Regional Clinical Director/RCD). R1's wound physician notes were reviewed with V12 and the notes contained an order for a pressure relieving boot and were electronically signed by the physician. V12 was asked if he felt like that is a physician order and should it have been processed as an order, V12 stated yes, it should have been placed in the orders. V12 stated if that is what the wound doctor thought he needed we should have made sure it was done.R1's Care Plan, Physician Orders, and Treatment Administration Records were reviewed and did not document an order for a pressure relieving boot for R1's right foot.On 2/17/2026 at 11:27AM, V9 (Wound Physician) stated he had placed the order for the pressure-relieving boot on his notes. V9 was asked why he placed the note for pressure relieving boot on his order sheet and V9 stated because that is what I do especially with a wound to the feet. V9 stated he can't say R1 was always noncompliant as he would always allow dressing changes to the wound, but he was noncompliant with lying down. V9 said R1 always wanted to be up in his wheelchair and around people. V9 stated I know the staff tried hard to get him to elevate his feet as well, but he didn't like to sit like that in his wheelchair. V9 stated he was aware that a boot was brought in by the family when R1 first arrived at the facility, but it didn't fit. V9 stated even a pillow pressure relieving boot would have helped some and V9 stated he did see R1 with a pillow boot a few times but not every time he was in the facility for rounds. V9 stated he was aware that R1 had his leg amputated but thought it was from infection in the chronic wound. V9 stated R1 needed to keep pressure off of his right foot. On 2/17/2026 at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:49 AM, V20 (Assistant Director of Nursing/Wound Nurse) stated she had never seen R1 with a boot on his foot and was not aware that there was an order on the wound doctor notes for a pressure relieving boot. V20 stated she makes rounds with V9, and she writes down the orders as they go and then she puts them in. V20 stated she doesn't really look at the notes after they are sent because she has already put in the orders. The facility policy titled Preventative Skin Care dated June 2025 documents #7) Pressure relieving devices may be used to protect heels and elbows. #8) ensure proper fitting wheelchairs, splints, braces, prosthetics, etc.

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record reviews, the facility failed to implement interventions for preventing deterioration of a pressure ulcer for 1 of 3 (R2) residents reviewed for wounds in a sample of 7. This failure resulted in worsening of R2's Stage IV pressure ulcer to the buttocks. The findings include:R2's admission Record documents an admission date of 8/10/2020 and includes diagnoses of Unspecified Sequelae of Cerebral Infarction, Pressure Ulcer of Right Buttocks (7/2/2025), Anemia, Hypertension, Schizoaffective Disorder, Psychosis, Vitamin D Deficiency, Hyperlipidemia, Vascular Dementia, Muscle Weakness, and Cognition Communication Deficit.R2's Minimum Data Set (MDS) dated [DATE] documents in section C, Cognitive Patterns, that R2 is rarely/never understood. There was no Brief Interview for Mental Status completed for R2. R2's cognitive skills for daily decision making is documented as severely impaired. Section GG, Functional Abilities, documents R2 is totally dependent on staff for all Activities of Daily Living (ADL's). Section H, Bladder and Bowel, documents R2 is always incontinent of bowel and bladder. Section M, Skin Conditions, documents R2 is at risk for developing pressure ulcers and R2 has 1 unhealed pressure ulcer that is a stage IV.R2's Care Plan documents Wound Prevention R2 has potential for pressure ulcer development/skin impairments related to incontinence, increased moisture potential, brief use, weakness and requires weight- bearing assistance with ADL's. Peri care provided by staff. End-stage skin failure of the right medial buttocks. Documented interventions include: 12/9/2024 monitoring any potential factors that could lead to skin alterations and prevent, if possible, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor/document/report to MD as needed changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (Length xWidth xDepth), stage. Wound physician to evaluate and treat as indicated.R2's Braden Scale assessment for risk of skin breakdown dated 1/1/2025 documents a total score of 12, indicating a high risk for skin breakdown for a score of 12 or less.The facility policy titled Preventative Skin Care with a review date of June 2025, documents under #6) Special mattress and or chair cushions will be used on any resident identified as high risk for skin breakdown. On 2/10/2026 at 3:55PM, V2 (Director of Nursing /DON) presented a wound log dated February 2026, that included R2's wound with acquired date of 7/2/2025, site of wound right medial buttocks, type of condition documented as end stage skin failure, and measurements of 0.9 Centimeters (cm) length (L) x 1cm width (W) x 2.5cm depth (D) with preventative equipment of air loss mattress.On 2/10/2026 at 3:59 PM, an observation was made of R2's bed and noted a standard mattress was on the bed. R2 was up in the dining room in her wheelchair at this time.On 2/13/2026 at 9:12AM, R2's bed was observed with a standard mattress still in place. R2 was up in her wheelchair with a noted pressure relieving cushion in place in the wheelchair.On 2/13/2026 at 9:20AM, V9 (Wound Physician) stated the first time he saw R2 she had a bad wound. It was deep, dark, and black, and a stage IV but I thought she was dying so I put the category of End of Life. V9 was asked how long he usually keeps end of life as a category for wounds, and V9 stated well I kept thinking she is going to die so I didn't change it so I will change it on my next rounds. V9 was asked what he would change the stage/category of this wound and V9 stated a stage IV Pressure Ulcer. V9 was asked if he thought R2 should be on an air loss mattress with a stage IV wound. V9 stated well that is their policy and protocol. V9 stated The air loss mattresses are great if they used appropriately and the staff are trained on setting those correctly. V9 stated he would make sure she has everything in place when he makes rounds.On 2/13/2026 at 10:15AM, V2 and V13 (Social Service Director/SSD) were observed placing an air loss mattress on R2's bed.On 2/13/2026 at 10:20AM, this surveyor spoke with V1 (Administrator) and V14 (Administrator from Sister (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Facility) and informed them of the concerns with R2 not being on an air loss mattress with a stage IV wound. V1 stated she was not aware that R2 was not on an air loss mattress and V14 stated she thought R2 had just been moved from another room, and the air mattress did not get moved with her and they were getting this fixed immediately.On 2/13/2026 at 10:32AM, V12 Regional Clinical Director (RCD) was asked if he expected a resident with a stage IV wound to be on an air loss mattress. V12 stated yes, I do expect the resident to be on an air loss mattress. V12 was asked if a resident that has a stage IV wound to the buttocks and was not on an air loss mattress could this contribute to the deterioration of the wound or prevention of healing appropriately and V12 stated yes it definitely could. R2's Wound Evaluation and Management Summary by V9 document for the following dates were reviewed and document measurement of R2's right medical buttock pressure wound: 12/24/2025: 0.7cm L x 1cm W x 1.8cm D.12/31/2025: 1cm L x 1.2cm W x 2 cm D.1/7/2026: 1cm L x 1.1cm W x 2cm D.1/14/2026: 0.5cm L x 0.5cm W x 2.5cm D.1/21/2026: 0.7cm L x 0.8cm W x 3 cm D.1/28/2026: 1cm L x 1.2 cm W x 2.7cm D.2/4/2026: 1cm L x 1.2cm W x 2.6cm D.2/11/2026: 0.9cm L x 1cm W x 2.5cm D.On 2/13/2026 at 10:50AM, the pressure ulcer treatment to R2's Right Medial Buttocks by V11 (Licensed Practical Nurse/LPN) was observed. V11 removed existing dressing and cleaned area with Wound Cleanser. R2's wound was measured by V11 and resulted in wound measurements of 1.2 Centimeters (cm) Length (L) x 1 cm Width (W) x 4cm Depth (D). V11 was asked if R2 was on an air loss mattress prior to today and V11 stated I really don't know I don't usually work this hall. V8 (Certified Nurse Assistant/CNA) was asked if she remembers R2 being on an air loss mattress in her other room before the room change to current room and V8 stated she just remembers R2 being in a different room, but she doesn't remember if she was on an air loss mattress in the other room. On 2/13/2026 at 11:07AM, R2's census sheet with the most recent room moves was requested from V15 (Business Office Manager). The document provided documented that R2's most recent room move was on 11/11/2025. V15 was asked to double check and make sure this was the last room move and V15 stated yes, this was the last room move for (R2). On 2/13/2026 at 12:08PM, V2 (DON) was asked if R2 had an air loss mattress before she changed rooms on 11/11/2025, V2 stated yes, she was. V2 was asked why the air loss mattress was not moved with her when she changed rooms on 11/11/2025 and V2 stated I just don't know. V2 was asked if he felt R2 still needed the air loss mattress at that time and V2 stated yes but I don't know how that happened and how we missed it all that time. On 2/13/2026 at 1:24PM, V16 (Medical Director/Primary Physician) stated, I expect the facility to follow policy and procedures they have in place, and I remember R2's wound was bad in July of 2025. V16 stated the air mattress would have helped and without air loss mattress it can cause the wound to deteriorate. V16 stated R2 should be on an air loss mattress.R2's Progress Notes dated 2/17/2026 at 1:24PM documents V9 informed of deeper measurement of wound. New orders received to obtain culture of wound.