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 04/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to answer call lights in such a manner to promote resident dignity and provide timely assistance for 2 of 2 residents (R6 and R24) reviewed for resident rights in the sample of 25. Findings include:1. R24's admission Record documented an admission date of 7/16/25 and included diagnoses of anxiety disorder, chronic kidney disease, and essential tremors. R24's MDS (Minimum Data Set) assessment dated [DATE] documented a BIMS score of 11, indicating moderate cognitive impairment. R24's Care Plan documents R24 is a fall risk (initiated 8/22/25) and included corresponding interventions to be sure R24's call light is within reach and encourage R24 to use it for assistance as needed. R24 needs prompt response to all requests for assistance (initiated 8/22/25). On 3/31/26 at 1:35 PM, R24's call light was observed to be already activated at 1:35 PM. Continuous observation revealed the call light to be answered by V6 (Assistant Director of Nursing/ADON) at 1:56 PM. R24 stated she always has a long wait when she puts her call light on. R24 stated she usually has to wait at least 20 minutes. V6 stated she got to R24 as quickly as she could, but they had more CNA's (Certified Nursing Aides) call in today and she was working the floor to help. 2. R6's admission Record documented an admission date of 3/2/22 and included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, morbid obesity, cystitis, weakness, and polyarthritis. R6's MDS assessment dated [DATE] documented a BIMS score of 12, indicating moderately impaired cognition. Under Functional Abilities and Goals, the MDS documented R6 as dependent with toileting hygiene, meaning the helper does all the work. R6's Care Plan documents R6 has bowel/bladder incontinence and requires assistance with toileting (initiated 4/28/20). The same Care Plan documents R4 displays behavioral symptoms related to turning the call light on, staff will answer the call light, and as soon as staff walks out, call light is turned back on (initiated 6/27/25). Corresponding interventions document, once call light is turned on, staff will go see what R6 needs and once staff have completed care if R6 turns the light on after leaving the room, staff will go back into room to verify if she needs anything (initiated 6/27/25). On 3/19/26 at 9:41 AM, this surveyor observed R6's call light already activated. During continuous observation, this surveyor observed V10 (Activities Director) go into R6's room. V10 did not ask R6 if she needed anything, then left room and the call light remained on. R6 stated to this surveyor, she needs to be cleaned up, she was incontinent. At 9:57 AM, V38 (Medical Records) came into the room and asked R6 if she needed something and she said she needed cleaned up. V38 said she would get someone to help R6. At 10:00 AM, V15 and V23 (both CNA's) came into R6's room to clean her up. V15 stated she is the only one on this hallway and she is training V23 because it is her first day. On 4/20/26 at 9:46 AM, V7 (Regional Director of Clinical Services) stated they do not have a policy related to call lights. On 4/21/26 at 1:23 PM, V1 confirmed they do not have a policy related to call lights that she is aware of. V1 stated anyone can answer call lights so she would hope that within 15 minutes max that someone has answered the call light.

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the physician and resident representative of an elopement event for 2 of 5 residents (R1 and R2) reviewed for notifications in a sample of 25. Findings include:1. R1's admission Record documented an admission date of 9/5/25 and included diagnoses of dementia, osteoarthritis of knee, and hypertension. R1's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 07, indicating R1's cognition is severely impaired. Section E of this same MDS assessment, titled Wandering-Presence and Frequency documents, this behavior occurred daily. R1's document titled Risk Management dated 3/6/26 at 11:30 AM documents under Nursing Description resident noted to be up the street pushing her friend to go look at cemetery, no s/s (signs/symptoms) of injury noted, resident brought back to facility in company van. Under Resident Description, it documents I was just going to show her my Mom and Dad's grave and under Description of Action Taken it documents resident noted to be up the street pushing her friend to go look at cemetery, no s/s of injury noted, resident brought back to facility in company van, assessed and brought back to facility per (name) another resident, they followed the smokers out and went the opposite direction. RCA (Root Cause Analysis)-confusion, thinks she is in community. Immediate intervention-staff educated that if resident is noted to be wearing makeup they should monitor for increased elopement risk. There is no documentation of physician notification in this document. R1's Progress Note created on 3/18/26 at 11:32 AM and effective on 3/6/26 at 11:32 AM created by V1 documents resident noted to be up the street pushing her friend to go look at cemetery, no injury noted, resident brought back to facility. RCA (Root Cause Analysis)-confusion, thinks she is in community. Immediate intervention-staff educated that if resident is noted to be wearing makeup they should monitor for increased elopement risk. 2. R2's admission Record documents an admission date of 9/11/25 and included diagnoses of anxiety disorder, chronic obstructive pulmonary disease, muscle weakness, cerebral atherosclerosis, primary hypertension, history of falling, metabolic encephalopathy, and osteoarthritis. R2's MDS assessment dated [DATE] documents a BIMS score of 04, indicating R2's cognition is severely impaired. R2's document titled Risk Management dated 3/6/26 at 11:30 AM documents under Nursing Description resident went with roommate on a ?walk,' no s/s of injuries noted. Under Resident Description, it documents I told her we should head on back and under Description of Action Taken it documents resident went with roommate on a ?walk' no s/s/ of injury noted. Per (name) another resident, they followed the smokers out and went the opposite direction. RCA-went for a walk with friend. Immediate intervention-resident educated to let staff know if roommate talks about going for a walk. There is no documentation of physician or family notification in this document. R2's Progress Note created on 3/18/26 at 11:39 PM and effective 3/6/26 at 11:38 AM documents Late Entry: Note Text: resident went with roommate on a walk, no s/s of injuries noted RCA- went for a walk with friend. Immediate intervention- resident educated to let staff know if roommate talks about going for a walk On 3/19/26 at 2:13 PM, V14 (Power of Attorney/Family Member) stated he was not notified when R2 eloped from the building on 3/6/26. V14 stated he was told on 3/18/26 when he came to the facility for a care plan meeting. On 3/18/26 at 12:39 PM, V17 (Registered Nurse/RN) stated she was the nurse working R1 and R2's hall when they eloped on 3/6/26. V17 stated she doesn't know how they got out or how long they had been gone. V17 stated she did not notify the physician. On 3/18/26 at 12:30 PM, V1 stated the physician was not notified when R1 and R2 eloped on 3/6/26. A facility policy titled Elopements dated 2026 documents under Policy Interpretation and Implementation, 3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: b. Notify the Attending Physician, c. Notify the residents legal representative (sponsor) of the incident, d. Document the notifications and exam in the resident's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to develop a comprehensive care plan that includes interventions to effectively communicate with a hearing-impaired resident for 1 of 3 residents (R4) reviewed for resident rights in a sample of 25.Findings include:R4's admission Record documents an admission date of 8/12/25 with included diagnoses of bilateral hearing loss.R4's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 12, indicating R4 has moderate cognitive impairment. Section B documents R4's hearing is highly impaired, absence of useful hearing and under ability to understand others it documents R4 usually understands, misses some part/intent of message but comprehends most conversation.R4's Comprehensive MDS dated [DATE] documents in Section B that R4's hearing is highly impaired, absence of useful hearing and under ability to understand others it documents R4 usually understands, misses some part/intent of message but comprehends most conversation. Under Care Area Assessment Summary, it documents Communication-Care Area Triggered, Yes.R4's current Care Plan did not document a focus area of R4's hearing loss and did not document R4's communication needs. R4's Progress Note dated 8/22/26 at 3:28 AM authored by V40 (Licensed Practical Nurse/LPN) documents Resident resting calmly in bed at this time. No s/s (signs or symptoms) of acute distress noted at this time. No c/o (complaint of) pain or discomfort voiced this date. Up ad lib (freely), feeds self with setup. Alert and able to make needs known well. Deaf but can read lips very well. This nurse communicates with text to speech function on device. Resident able to read well. Breathing even and non labored, no cough noted this date.R4's Progress Note dated 2/3/26 at 11:21 PM authored by V21(Registered Nurse) documents Resident alert & Oriented x4. Able to make needs known. Resident Deaf, but communicates reading lips. Speech clear. Resident does not seem to grasp the severity that he has Cancer that has spread that is making him feel ?not good.' Resident states ?what are you guys even doing for me' ?what are you doing for my cough and shoulder' Resident was started on the meds listed above and also given Tylenol to help manage pain. Resident has a care plan meeting 2/4 to discuss care. Resident reminded that he has been referred to Oncology in relation to his Cancer spreading. Call light within reach. plan of care to continue.On 4/6/26 at 11:14 AM, V37 (Certified Nursing Aide) came into R4's room to pull him up in his chair and V37 walked to his bathroom and was talking to him while she was in the bathroom, with her face out of R4's sight. R4 stated to this surveyor that he didn't know what V37 was saying, he couldn't hear her. This surveyor asked V37 if she knew R4 was deaf, and V37 replied she was told that R4 could hear in one ear.On 4/21/26 at 1:28 PM, V9 (MDS Coordinator) stated if the MDS assessment triggers a care area it should be care planned in his care plan. V9 stated she doesn't know why communication isn't care planned for R4 because it should be. V9 stated she thinks she might have missed the care area trigger and didn't put it in his care plan. V9 stated since R4 is deaf and sometimes struggles to read lips that a dry erase board in his room would help with communication. V9 stated when she is talking to R4 he will start to look away and she has to wave her hand in front of him to get him to look back to her to communicate. V9 stated she doesn't know how R4's communication needs are communicated with the rest of the staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide dependent residents with timely ADL (Activities of Daily Living) assistance for diabetic toenail care and shaving for 5 of 5 residents (R4, R11, R17, R18, R25) reviewed for ADL assistance in a sample of 25. Findings include: 1. R4's admission Record documented an admission date of 8/12/25 and included diagnoses of type 2 diabetes, muscle weakness, unsteadiness on feet, other fatigue, and bilateral hearing loss. R4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Under Functional Goals and Abilities, this MDS documents R4 needs supervision or touching assistance for personal hygiene. R4's Care Plan documents an ADL self-care performance deficit related to chronic disease process. R4's Order Summary Report documents may see podiatrist with an order date of 8/12/25. On 4/16/26 at 11:01 AM, V4 (License Practical Nurse/LPN) observed R4's toenails with this surveyor present. R4's toenails were long and wrapping around the end of his toes, extending to underneath of his toes. V4 stated R4's toenails needed trimmed, and she doesn't know why they haven't been trimmed. V4 stated they used to have a podiatrist come to the facility, but they don't have one that comes to the facility anymore. 2. R25's admission Record documented an admission date of 9/8/22 and included diagnoses of type 2 diabetes, Alzheimer's disease, muscle weakness, and need for assistance with personal care. R25's MDS assessment dated [DATE] documented a BIMS score of 07, indicating severe cognitive impairment. Under Functional Abilities and Goals, the MDS documented R27 is dependent with personal hygiene, meaning the helper does all the effort. R25's Care Plan documents R25 has an ADL self-care performance deficit related to weakness and requiring assistance with ADLs. R25's Order Summary Report documents may see podiatrist with an order date of 11/18/25. On 4/16/26 at 11:15 AM, V4 (LPN) observed R25's toenails with this surveyor present. R25's toenails were thick and needed trimmed. V4 stated she wouldn't feel comfortable trimming R25's toenails due to the thick growth of the nails and stated R25 needs a podiatry referral. 3. R11's admission Record documented an admission date of 12/27/22 and included diagnoses of type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, borderline intellectual functioning, and muscle weakness. R11's MDS assessment dated [DATE] documented a BIMS score of 13, indicating intact cognition. Under Functional Abilities and Goals, the MDS documented R11 needs supervision or touching assistance with personal hygiene. R11's Care Plan documents R11 has a diagnosis of type 2 diabetes initiated 1/26/23 with included interventions refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails initiated 1/26/23. R11's Order Summary Report documents may see podiatrist with an order date of 7/22/24. On 4/16/26 at 11:08 AM, V4 observed R11's toenails with this surveyor present. R11's toenails were long and V4 stated they needed trimmed. R11 stated her toes are painful and her toenails need trimmed. 4. R18's admission Record documented an admission date of 6/5/24 and included diagnoses of Parkinson's disease, dementia, muscle weakness, and other lack of coordination. R18's MDS assessment dated [DATE] documented a BIMS score of 05, indicating severely impaired cognition. Under Functional Abilities and Goals, the MDS documented R18 is dependent with personal hygiene. R18's Care Plan documents an ADL self-care performance deficit related to dementia, Parkinson's, and impaired balance with generalized weakness initiated 6/7/24. On 3/25/26 at 2:43 PM, this surveyor observed facial hair on R18's face and asked R18 if the staff shave his face. R18 stated well, as you can see, they haven't and stated he doesn't like having facial hair. R19 (R18's roommate/family member) stated they only have one girl at the facility that can shave so (R18) has to wait until she has time. 5. R17's admission Record documented an admission date of 6/27/25 and included diagnoses of arthritis and glaucoma. R17's MDS assessment dated [DATE] documented a BIMS score of 11, indicating moderately impaired cognition. Under Functional Abilities and Goals, the MDS documented R17 is dependent with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal hygiene, meaning the helper does all the effort. R17's Care Plan documents ADL's: R17 has limited physical mobility related to COPD (Chronic Obstructive Pulmonary Disease) and being on oxygen. On 3/25/26 at 10:31 AM, this surveyor observed facial hair on R17's face. R17 stated they don't shave him very often, but he would like to be shaved. R17 stated he gets showers 2 times a week and they didn't shave him with his last shower. On 3/30/26 at 3:05 PM, R17 was observed with facial hair and stated he was told he is getting a shower tomorrow and they would shave him then. On 3/31/26 at 3:00 PM, R17 was again observed with facial hair and dirty appearing hair. R17 stated they didn't get him up for a shower yesterday, they gave him a bed bath and didn't wash his hair or shave him. R17 stated he doesn't know why they didn't get him up for a shower, shave him, or wash his hair and stated he didn't refuse any of it. R17 stated the CNA's are always in a hurry and act like they don't have time to do anything. R17 stated he is sick and tired of bed baths and wants a shower. On 3/31/26 at 3:48 PM, V37 (CNA) stated she gave R17 his bed bath and she didn't shave him or wash his hair. V37 stated R17 didn't want shaved. On 4/16/26 at 11:01 AM, V4 (LPN) stated the nurses are supposed to trim toenails for diabetic residents and she doesn't know if toenails are supposed to be trimmed on shower days or on skin check days, but the CNA's should let the nurses know if a diabetic resident needs their toenails trimmed. On 4/16/26 at 12:02 PM, V6 (Assistant Director of Nursing/ADON) stated the nurses oversee trimming toenails for diabetic residents but it always ends up being her because the nurses don't do it and she hasn't had time to trim toenails due to being short staffed. On 4/16/26 at 11:20 AM, V1 (Administrator) stated toenail care for diabetic residents should be done when the nails need trimmed. V1 stated there isn't a schedule or any one nurse in charge of diabetic toenail care, it should just be done when they see the toenails need trimmed. V1 stated they don't have a podiatrist that comes to the facility, they refer out for that. On 3/31/26 at 3:06 PM, V6 (ADON) stated residents are supposed to be shaved on shower days and in between as needed/requested by residents. On 4/20/26 at 10:57 AM, V7 (Regional Director of Clinical Services) stated they do not have a policy regarding shaving of residents' faces. A facility policy titled Care of Fingernails/Toenails dated 2022 documents under Purpose: The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. Under Steps in the Procedure: 5. RNs (Registered Nurses) to trim toenails of a diabetic mellitus resident.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, interview, and record review, the facility failed to ensure care and services were provided to ensure a resident's highest level of practicable functioning for 1 (R4) of 3 residents reviewed for quality of care in a sample of 20. This failure resulted in R4 not receiving timely follow-up and treatment of known suspicious masses which have since metastasized. This failure resulted in Immediate Jeopardy, which was identified to have begun on 1/30/26 when the facility failed to follow through with referrals to an outside provider. V1 (Administrator), V3 (Senior Regional Administrator), and V7 (Regional Director of Clinical Services) were notified of the immediate jeopardy on 4/9/26 at 11:25 AM. The immediacy was removed on 4/9/26, but non-compliance remained at a Level Two because time is needed to evaluate the implementation and effectiveness of in-service training. Findings include: R4's admission Record documented an admission date of 8/12/25 and included diagnoses of chronic obstructive pulmonary disease, type 2 diabetes, abnormal findings on diagnostic imaging of lung, muscle weakness, unsteadiness on feet, other fatigue, and bilateral hearing loss. R4's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. R4's Care Plan documents R4 is at risk for falls related to deconditioning, gait/balance problems, and vision/hearing problems. On 3/19/26 at 9:29 AM, R4 stated he has constant pain in his back, chest, and left arm/shoulder. R4 stated he was told he had cancer that was spreading and that is why he is having pain. R4 stated he keeps being told they are trying to get him an appointment for his cancer, but he still hasn't been to the doctor. R4 stated he isn't sure if they are even doing anything to help him. R4 stated he wants to get treatment for his cancer. R4's Progress Note dated 1/12/26 at 12:33 PM created by V6 (Assistant Director of Nursing/ADON) documented (V28, Nurse Practitioner) in facility to see res (resident). Res has c/o (complaints of) abd (abdominal) discomfort this AM that has somewhat subsided, last bm (bowel movement) yesterday that was large et (and) not hard per res. n.o. (new order) rec'd (received) for gas-x/simethicone tabs q4 prn (every 4 hours, as needed) for gas/bloating. R4's Progress Note dated 1/15/26 at 12:52 AM created by V6 documented Rec'd n.o. per (V28) to obtain cbc (complete blood count), cmp (comprehensive metabolic panel), lipase, thyroid panel, vit (vitamin) d, b12, lipid panel. CT (Computed Tomography, diagnostic imaging procedure) of abd/ pelvis with contrast. R4's Progress Note dated 1/22/26 at 11:04 AM created by V6 documented CT of abd scheduled for 1/28 at 0715 (7:15 AM). res to be npo (nothing by mouth) 4 hrs (hours) prior. to appt. res notified R4's CT Abdomen Pelvis results from local hospital dated 1/28/26 documented under Impression: nodular opacity in the right lower lobe with involvement and expansion of the right seventh rib. Findings suspicious for primary lung neoplasm with invasion. Tissue sampling and pulmonary consultation advised. Left hepatic lesions suspicious for metastatic disease. Enlarging bilateral adrenal nodules measuring up to 3.6 cm (centimeters) on the right and 4.1 cm on the left. Findings are suspicious for metastatic disease. Mild height loss of T11 vertebral body, new from prior with possible lucent lesion. Acute fracture is not excluded. R4's Progress Note dated 1/29/26 at 2:20 PM created by V4 (License Practical Nurse/LPN) documented Resident started complaining of left shoulder pain and states he doesn't know when it started but he can't lift his left arm up without pain being resulted. Resident states it doesn't hurt when you touch it, only when he goes to lift his arm up. (V19/Physician) notified and asked to obtain x-ray. R4's Progress Note dated 1/30/26 at 1:14 PM created by V4 documented X-ray results received and sent to (V19, Physician). (V19) orders oncology referral. Oncology referral faxed to (oncology facility) d/t (due to) abnormal CT of the abdomen and x-ray of left shoulder. (phone number). R4's Radiology Results Report dated 1/30/26 documents under Procedure: Left Shoulder, complete, 2+ views, under Clinical Information: new onset pain and limited range of motion, and under Impressions: 1. Lytic humeral mass (area of destroyed bone tissue) 2. No acute fracture or dislocation. R4's Order Summary Report documents an order dated 1/30/26 for an (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	oncology referral due to an abnormal CT of the abdomen and an abnormal x-ray of left shoulder. R4's Progress Note dated 1/30/26 at 1:58 PM created by V4 documented Referral, face-sheet, med orders, x-ray report, and CT report all faxed. R4's Progress Note dated 2/3/26 at 11:21 PM created by V21 (Registered Nurse/RN) documented Resident alert & Oriented x (times) 4. Able to make needs known. Resident Deaf, but communicates reading lips. Speech clear. Meds (medications) taken whole. Up ad lib (freely). Steady gate, but experiencing weakness r/t (related to) to dx (diagnosis) of Cancer. set up assist with meals and showers. feeds self. Independent with ADLS (activities of daily living). Cont (continent) to B&B (bowel and bladder). room air. NCS (no concentrated sweets diet), regular texture, thin liquid diet. Blood sugar and insulin provided per orders. Continues on OT (Occupational Therapy). HOB (head of bed) elevated r/t COPD (Chronic Obstructive Pulmonary Disease). Afebrile 97.6. VS (vital signs) wnl (within normal limits). C/o (complaints of) pain to Abd and BUE (bilateral upper extremities), PRN (as needed) Tylenol provided per orders. Resident referred to Oncology. Resident continues on Mucinex 400mg TID (three times a day) x 1 week, Duonebs Q6h (every 6 hours) x 1week, and Prednisone 40mg daily x 5Days. Tolerated all well. No ADR (adverse drug reaction). Afebrile. Resp even and unlabored. Fluids offered and encouraged. Resident does not seem to grasp the severity that he has Cancer that has spread that is making him feel not good. Resident states what are you guys even doing for me what are you doing for my cough and shoulder Resident was started on the meds listed above and also given Tylenol to help manage pain. Resident has a care plan meeting 2/4 to discuss care. Resident reminded that he has been referred to Oncology in relation to his Cancer spreading. Call light within reach. plan of care to continue. R4's Progress Note dated 2/4/26 at 3:18 PM created by V31 (Former Director of Nursing) documented Spoke with (Oncology clinic) for an update on referral sent last week. They stated that they did not receive a referral. I did obtain a direct fax number for their referral dept. (department) (phone number). Face sheet, CT results, and x-ray results were faxed to medical oncology as well as radiation oncology. (V27, Family Member/Power of Attorney/POA) still in facility from earlier care plan meeting and aware of referral faxed. R4's Progress Note dated 2/5/26 at 8:46 AM, created by V8 (Social Services) documented (R4) stated to me while I was doing his MDS, that he feels down because he's not feeling good and that his health is failing. He also don't have the energy like he did before when he got here. He still wants to do activity and move around. The facility's fall incidents report documents R4 had three falls on 2/19/26, 2/21/26 and 2/22/26. R4's Progress Note dated 2/19/26 at 3:37 AM, created by V32 (LPN) documented immediate full body assessment rom (range of motion) as before moves both legs no rotation or shortening. is very weak in left arm cannot grip or raise arm. explained to resident that if he wants to get up from bed or chair to use his call light if he feels he can not get up on own aknowledged [sic] his understanding and took the call light. v/s (vital signs) 97.7-86-18-145/77-02 sat (saturation) 97% on room air room was free of clutter floor was dry bed was in low position. Dr. (doctor) notified of above at 7am DON (Director of Nursing) notified of above POA (V27) notified of above 710am. R4's Progress Note dated 2/21/26 at 2:51 PM created by V1 (Administrator) documented resident noted on floor in room by housekeeping staff, nurse alerted and assessment completed, VS 97.3, 69, 22, 162/68, 92%, resident already has c/o pain in L (left) arm, monitored by nurses for pain r/t (related to) dx (diagnosis) RCA (root cause analysis)- lost balance when self transferring. Immediate intervention- educate resident to use call light and ask for assist R4's Progress Note dated 2/22/26 at 1:50 PM created by V4 documented This nurse was responded to a resident yelling ah help! to resident's room. Upon immediate observation, resident was observed laying on his back in-front of his room mate's dresser. Resident questioned on what happened and how he fell and resident stated I don't know, I just got weak. Baseline is alert and orientated x4 and aware of placement at facility. Resident stood back up off the floor via 1x assist. Neurological exam performed and within normal limits. V/S: 98.1, 70 pulse, 20 respiration, 126/71. Resident denies any new pain. Head to toe assessment completed with no new injuries. ROM x4 without new pain. Resident unable to move resident's left arm d/t last x ray obtained. No deformity or shortening to (continued on next page)

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 04/22/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	extremities. (V19/Physician) to be notified. R4's Progress Note dated 2/23/26 at 9:45 AM created by V4 documented (V28/Nurse Practitioner) in facility and this nurse requested her to see resident d/t fast decline and increased weakness. (V28) ordered a CBC, CMP, a repeat x-ray to left shoulder and bicep, and to wear a sling to left arm at all times d/t resident no longer wanting to move that arm. (V27/Power of Attorney/Family Member) notified via phone call. R4's Radiology Results Report with examination date of 2/23/26 documents under Procedure: Left humerus 2+ views, under Clinical Information: Pain, and under Impressions: Large focal lucency of the proximal left humerus suspicious for metastatic disease, now with pathologic fracture of the humeral diaphysis proximally. Under Procedure: Left Shoulder complete 2+ views and under Impression: Known pathologic proximal humeral fracture associated with prominent mass is not identified on this extremely limited examination, pathologic fracture of the left 6th rib with focal lucency. On 3/19/26 at 9:40 AM, V18 (Director of Rehab) stated they have been working with R4 with pain management, positioning, and strengthening. V18 stated R4 is in a lot of pain due to his cancer diagnosis. V18 stated she isn't aware of R4 having any falls or having a fracture in his arm. R4's Progress Note dated 2/23/26 at 10:53 AM created by V4 documented Contacted (Oncology facility) and spoke to (name of oncology facility staff) and voiced they didn't receive referral until yesterday evening despite several confirmations on our end. (name) states she did receive the one that this nurse faxed over yesterday evening and will work on them in the order they received them. No ETA (estimated time of arrival) able to be given. (V27) notified and thankful to this nurse. R4's Progress Note dated 2/25/26 at 11:48 AM created by V6 documented (Orthopedic clinic) called et (and) spoke c (with) (name of Orthopedic clinic staff) to make appt (appointment) r/t humerus. (Name of orthopedic clinic staff) asked to have (x-ray company) send images over and to fax x-ray results. stated she will have to call on call dr (doctor) to decide on appt date. call back name et number given at this time. R4's Progress Note dated 2/25/26 at 12:22 PM created by V6 documented spoke c (oncology clinic). stated they didn't see res referral that was faxed et confirmation paper rec'd (received). referral refaxed to (phone number). R4's Progress Note dated 2/27/26 at 1:20 PM created by V6 documented (oncology clinic) was called et spoke c (name of oncology clinic staff) in referral dept r/t res referral faxed. stated they had not rec'd it yet. rec'd another fax number of (number) to fax to. referral faxed again at this time R4's Progress Note dated 2/27/26 at 1:23 PM created by V6 documented R4 has an orthopedic appointment on 3/2/26 at 1:30 PM. R4's Order Summary Report documents an order dated 3/6/26 for an urgent referral to pulmonology related to abnormal CT results and oncology. R4's Progress Note dated 3/6/26 at 12:28 PM created by V6 documented referral faxed to pulmonology at this time. onocology [sic] stated needed biopsy before tx. R4's Progress Note dated 3/11/26 at 3:03 PM created by V6 documented V19's (Physician) office called and gave an order for a stat interventional radiology guided pulmonology biopsy. R4's Order Summary Report documents an order dated 3/11/26 for a stat interventional radiology guided pulmonology biopsy. R4's Progress Note dated 3/11/26 at 3:12 PM created by V6 documented a referral was faxed to interventional radiology. R4's Progress Note dated 3/14/26 at 8:53 PM created by V30 (Registered Nurse/RN) documented late entry for 3:15 pm. resident in room with family for visit, is voicing c/o ongoing pain to arms, back, shoulders, and generally all over and voices the pain medication is not helping to stop his pain. after resident was assessed by this nurse for newiinjury [sic], with no new visible changes to areas of concern. (V19/Physician) notified with orders to repeat pain medication x 1 and continue to monitor. medication given per orders and continue to monitor. daughter in facility and updated and voices content with the update. resident again instructed to call with any new issues or change instatus [sic], at this time he has voiced agreement. call light within reach and resident back to bed and voices is comfortable. R4's Progress Note dated 3/18/26 at 2:41 PM, created by V6 documented interventional radiology called related to biopsy order and stated it was denied related to interventional radiology imaging protocol and gave number for her to call to see what is needed. R4's Progress Note dated 3/18/26 at 2:52 PM created by V6 documented (interventional radiology facility) (continued on next page)

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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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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	called et spoke c (name). stated she was unsure of information that this writer gave et requested to have orders et imaging faxed to her et she would review et give this writer call back et try to remedy issue. call back name et number given. information faxed (number). R4's Progress Note dated 3/24/26 at 9:10 AM created by V1 (Administrator) documented spoke with (interventional radiology facility) this AM regarding IR (interventional radiology) lung biopsy, staff at (interventional radiology facility) he needed more imaging, called physician regarding imaging, he stated to attempt to schedule arm biopsy, if (interventional radiology facility) continues to ask for imaging, schedule CT with and without contrast, DON working on scheduling now R4's Progress Note dated 3/24/26 at 2:18 PM created by V2 (Director of Nursing/DON) documented spoke w/ (interventional radiology facility), states referral process would need to be restarted for new biopsy site. notified MD, MD gave order for CT w/ et w/o (without) contrast of chest. order faxed to (local hospital) central scheduling. CT scheduled for 3/26/26 at 9am. resident to have lab draw at (local hospital) prior to imaging on day of. resident to be NPO starting 4 hours prior to imaging. transport made aware, resident made aware. R4's Progress Note dated 3/25/26 at 10:34 PM created by V33 (LPN) documented This nurse called and spoke w/ (V19) at this time regarding residents current pain. This nurse explained to (V19) that even with PRN [NAME] (Tylenol), and medication increased to q6hr (every 6 hours) instead of q8hr (every 8 hours), resident was still experiencing breakthrough pain. Scheduled norco givin [sic] at 11AM. Will cont (continue) to monitor. R4's CT chest results from local hospital dated 3/26/26 document under Impression: Larger right lower lobe subpleural mass consistent with primary bronchogenic malignancy destroying right ribs 7 and 8. New hepatic metastases. New bilateral adrenal metastases. Additional metastatic lytic lesion with associated pathologic fracture of right rib 7. Metastatic soft tissue mass destroying left humeral head. Acute to subacute new burst fractures of T5 and T11 with lytic lesion associated with the 11 suspicious for pathologic fracture. On 3/26/26 at 2:49 PM, V27 (Family Member) stated she was told by V1 that R4 has cancer that has spread, and his arm is deteriorating due to the cancer, and he has a broken arm. V27 stated she doesn't know why they don't take him to the doctor for his cancer or his broken arm. V27 stated she was told by his pulmonologist back in September 2025 that R4 had a spot on his lung, but it was shrinking so they could wait to do a biopsy because they didn't have the money to pay for the biopsy at that time. V27 stated now that he has cancer that has spread, she nor R4 have told the facility they don't want treatment for R4, she stated they want him to get treatment for his cancer. V27 said back in August or September 2025 they canceled an appointment due to not having the finances to pay for it but now that he has known cancer that has spread R4 wants treatment, and she agrees with him. R4's Progress Note dated 3/29/26 at 2:00 PM created by V4 documented Resident stating he can't breathe. Oxygen saturation checked and was 90%. (V27) in room at this time requesting resident to have oxygen placed. Resident agrees to wear it right now. 2L (liters) via NC (nasal cannula) placed and oxygen rose to 95%. On 3/30/26 at 2:29 PM, V6 (ADON) stated R4 was admitted with a lesion on his lung. V6 stated in September 2025, V27 canceled an appointment for R4 and V6 was told by someone at the facility it was due to (R4) not having the money to pay for the doctor's visit. V6 stated in January 2026, R4 began complaining of abdominal pain and he had an x-ray that showed bowel gas; then on 1/29/26, R4 had a CT of the abdomen, and it showed some lesions so V19 ordered a referral to oncology on 1/30/26 and it was faxed on that day. V6 stated the previous director of nursing called and checked on the referral on 2/4/26 and re-faxed it then. V6 stated no one called to check on the referral until 2/23/26 when V4 (LPN) called and re-faxed the referral. V6 stated on 3/6/26 she received a call from oncology stating R4 needed to see pulmonology and needed a biopsy before they could see R4, so V6 faxed an order per V19 to pulmonology for a referral. V6 stated she received a phone call on 3/11/26 from V19's office stating V19 wanted a referral sent to interventional radiology for R4 to get a biopsy, so V6 faxed an order to them. V6 stated on 3/18/26 she called interventional radiology to see if they received the referral and they told V6 they couldn't do the biopsy because they didn't have the correct imaging and told V6 to call (outside radiology company) to see what else (continued on next page)

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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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V6 stated they didn't call and reschedule the appointment, they no showed to the appointment, and it hasn't been rescheduled yet that V6 knows of. V6 stated she hasn't done anything else at this point with the referrals and as far as she knows, as of today R4 does not have an appointment with oncology, pulmonology, orthopedics, or had a biopsy. V6 stated since the new findings on the CT from 1/30/26, neither R4 nor V27 have refused treatment. V6 was under the impression that due to the new findings R4 wanted treatment even though he didn't have Medicaid yet. R4's Progress Note dated 4/2/26 at 9:22 AM created by V4 documented CT results sent to (V19). R4's Progress Notes dated 4/2/26 at 9:55 AM, 10:20 AM, and 11:42 AM created by V4 documented interventional radiology was called and no answers. R4's Progress Note dated 4/3/26 at 10:03 AM created by V4 documented Contacted (local hospital) Referral team and faxed results to (number). Spoke to (name) who states once they receive the results, they will call facility and schedule an appointment for biopsy. (V27) contacted and notified. R4's Progress Note dated 4/7/26 at 2:29 PM created by V1 (Administrator) documented received note from ortho (orthopedic) visit this morning at approximately 1104 (11:04 AM), after 6 attempts at calling, I was able to speak with (provider at orthopedic clinic) who saw (R4) at his visit, he does feel like after reviewing the CT, (R4's) dx of mets (metastases) and the fall being low impact that it is a pathological fx (fracture). R4's Progress Note dated 4/9/26 at 2:43 PM created by V1 documented 1415 (2:15 PM)- (local hospital) called to obtain CD of images 1420 (2:20 PM) called (interventional radiology) regarding appointment- (name of representative at interventional radiology) stated it was not approved and directed me to call (interventional radiology sister facility), they stated it was denied r/t not having images, so she emailed them, 1454 (2:54 PM)-they then called back, said it was approved and that (V19's) office would have to call and schedule it. (V19's) office notified, no nurse available but receptionist would give message, I asked they call me back after scheduled with date and time (local clinic name) oncology called, stated they have to have biopsy before they can schedule, but (name of representative at oncology clinic) advised to send to radiation oncology for quicker appt due to not needing biopsy, referral faxed to (number)- stated it was STAT as directed by (name of representative at oncology clinic) 1440 (2:40 PM)- (local clinic name) pulmonology called, spoke with (name of representative at pulmonology clinic), referral and CT results sent to (number) R4's Progress Note dated 4/9/26 at 4:17 PM created by V1 documented (V19) sent mediprocity (secure messaging system) message at 1538 (3:38 PM) regarding IR appointment r/t order must come physician's office (local clinic name) pulmonology called again at 1548 (3:48 PM) to see if referral was received- per (name), it can take up to 24 hours for that to come through, try back tomorrow around 1500 (3:00 PM), this admin (administrator) did receive confirmation email/ fax stating it went through 1615 (4:15 PM) (local clinic name) radiation oncology called to verify they received fax- reached a voicemail for (name) in radiation oncology, left message, confirmation was received by this admin that fax/email went through R4's Progress Note dated 4/10/26 at 8:25 AM created by V1 documented spoke with (name) at (V19's) office, resident is scheduled for (local hospital name) IR appt on 4/20/26, they will possibly move this appt up to 4/16/26 if it is confirmed they have an opening. per (name) we need to put his aspirin on hold an (local hospital name) IR will call Monday 4/13/26 with time and preop orders R4's Progress Note dated 4/10/26 at 10:13 AM created by V1 documented calls made to the following this AM: radiation oncology- per (name) they received the fax/referral and a nurse would look at it and call us with an appt. pulmonology- spoke with (name), she initially stated (continued on next page)

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R4's Progress Note dated 4/13/26 at 12:26 PM created by V1 documented pulmonology at (local clinic name) called for f/u (follow-up), receptionist stated they received referral and it has been sent to office for review, double checked that they had our call back number, will notify POA message left for radiation oncology R4's Progress Note dated 4/13/26 at 1:19 PM created by V1 documented spoke with (name) at radiation oncology, resident scheduled 4/14 at 1000 am, needs to arrive 15 minutes early scheduled 4/20/26 at 1100, orders in place (V27) notified of appt on 4/14 and 4/20 voices she is unsure if she can make appt. On 3/30/26 at 1:12 PM, V19 (Physician) stated R4 was admitted to the facility with a known lung lesion from the hospital, but the facility reported to him that the family refused treatment for the lesion at that time. V19 stated in his professional opinion, R4's fracture of his left upper arm is thought to be from the mass but most certainly a fall onto that area could have caused a fracture. V19 stated he ordered a referral to oncology and for R4 to see his pulmonologist on 1/30/26. V19 stated oncology wouldn't see him without a biopsy first, so they referred him to IR for a biopsy of the lesion that was found on his lung, then V6 (ADON) told him R4 needed further testing before they can do a biopsy, so he ordered another CT scan. V19 stated he ordered for R4 to be sent to orthopedics after his x-ray on 2/23/26 due to the results stating he had a fracture in his arm, but he hasn't received any notes from ortho yet, so he isn't sure why he hasn't seen him yet. On 4/2/26 at 3:14 PM, V1 (Adminisrator) stated R4 went to his orthopedic (appointment) 3/27/26 but she doesn't know what they said because he didn't bring any papers back with him. On 4/2/26 at 11:35 AM, V27 (Family Member) stated she just received a call from V4 (LPN) stating R4's cancer had spread to his spine, ribs, shoulder, arm, adrenal glands, and liver. V27 stated R4 saw a pulmonologist in (neighboring state) and they wanted $700 for the bronchoscopy and to biopsy the lesion on his lung but they did not have that money at the time and the pulmonologist told them the lesion has shrunk so it would be okay to just recheck it in April 2026. V27 stated when she was told R4 had cancer in his lungs, liver, stomach, and bones in February 2026 she told the facility to get him wherever he needed to go, and she didn't tell them not to schedule any appointments due to finances because R4 wanted treatment. V27 stated she was never told that R4 had an orthopedic appointment scheduled for 3/2/26 and she didn't know he missed it either. On 4/6/26 at 2:24 PM, V6 (ADON) stated she found the fax confirmation paper from the pulmonology referral she sent on 3/6/26 and it says there was an error, and it didn't go through when she faxed it. V6 stated nothing else has been done with that pulmonology referral because she forgot about it. On 4/8/26 at 2:09 PM, V34 (Interventional Radiology Radiologist Assistant) stated R4's biopsy was denied due to not having the images from the CT, they only had the report. V34 stated she denied it, and the charge nurse would have called the provider to let them know why. V34 stated the CT scan they had from January 2026 was sufficient, but they needed the images. On 4/9/26 at 12:56 PM, V35 (Interventional Radiology Registered Nurse) stated they received a fax on 3/11/26 that just had R4's name on it and IR/pulmonary biopsy on it with no diagnosis so it is not a valid order. V35 stated they then received an order on 3/17/26 that was put into their electronic charting system by V19. V35 stated after they received that order on 3/17/26, she sent a message to V19 stating they needed the images from R4's CT scan before they could do the biopsy. V35 stated they haven't had any further communication regarding R4, but she does see in their system that R4 had another CT, but they were only sent the report again and not the actual images. V35 stated R4 still has an active order so as soon as they get the images to them, they can do the biopsy. On 4/9/26 at 7:28 AM, V19 stated he ordered a CT scan on 1/12/26 due to abdominal (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	bloating and that CT recommended tissue sampling and pulmonary consultation. V19 stated at that time he ordered R4 to have a referral to oncology and to see the pulmonologist R4 was already established with. V19 stated if R4 couldn't see his current pulmonologist due to it being too expensive, he should have been referred to a pulmonologist at the local healthcare system that is non-profit. V19 stated he was under the impression R4 was seeing the pulmonologist. V19 stated that on 3/3/26, his office stepped in to help with referrals because he noticed some of the referrals he ordered weren't getting done in a timely manner. V19 stated he isn't sure what the outcome would have been if R4 had been sent to his pulmonologist on 1/30/26 like he ordered, but they might have been able to get it biopsied faster and sent to oncology quicker as well. V19 stated R4 should have been referred to the pulmonologist when he ordered it and taken to his orthopedic appointment when it was scheduled. A document provided by the local oncology facility titled Referral documents on 3/3/26 Call made to (V6) at (facility name) regarding referral. Noted in CT scan results, recommendation was made for Pulmonary biopsy/workup for likely primary lung neoplasm. Requesting referral be placed urgently to Pulmonology at this time. (V6) verbalized she would pass this on to (V19). In the same document on 3/10/26, it notes Called (V19's) office and spoke with (name) regarding requested referral to Pulmonology. (name) states she will send urgent message for nursing to address. On 3/18/26 it documents Noted in chart that V19 placed an order on 3/17/26 for an IR CT needle biopsy lung. Will continue to monitor for biopsy to be performed and resulted. On 3/30/26 at 8:15 AM it documents At this time patient does not have a biopsy proven malignancy. PCP (Primary Care Provider) has not placed order to seen [sic] Pulmonology for lung biopsy/work-up as requested. This referral will be closed and a new referral will be placed if diagnosed with malignancy. On 4/13/26 at 2:05 PM, V7 (Regional Director of Clinical Services) stated they do not have a policy related to following physician's orders. The Immediate Jeopardy that began on 1/30/26 was removed on 4/9/26 when the facility took the following actions to remove the immediacy: 4/9/26 2:15 p.m. Administrator called Hospital Medical Records Department to obtain CD of images.4/9/26 2:40 p.m. Administrator called Pulmonology Facility and spoke with Pulmonology Facility Representative, updated referral and CT results sent to (phone number) as directed.4/9/26 2:42 p.m. Administrator called Oncology Facility to schedule an appointment. Oncology Facility Representative stated they must have a biopsy before they can schedule. CT does not suffice. Oncology Facility Representative advised facility to send the referral to Radiation Oncology for a quicker appointment because they do not require a biopsy. Referral faxed to (phone number) stating it was STAT as directed by Oncology Facility Representative.4/9/26 2:45 p.m. Administrator has called Interventional Radiology Facility regarding appointment. Interventional Radiology Facility Representative stated it was not approved and directed facility to call another Radiology Facility at (phone number). The second Radiology Facility stated it was denied r/t not having images, so they emailed them.4/9/26 2:54 p.m. The second Radiology Facility called back and said it was approved and that Primary Care Physician's office would have to call and schedule it. Primary Care Physician's office immediately notified. Requested Primary Care Physician's office to call facility back after it is scheduled with a date and time.4/9/26 3:38 p.m. Interim DON contacted Primary Care Physician directly requesting that he expedite the scheduling of the biopsy.4/9/26 3:48 p.m. Administrator contacted Pulmonology Facility again to see if referral was received. Per

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure cognitively impaired residents were adequately supervised and failed to implement interventions to prevent elopement for 2 (R1, R2) of 3 residents reviewed for accidents and supervision in the sample of 3. This failure resulted in R1 exiting the facility on 2 occasions, accompanied by R2 on one of those occasions, without staff knowledge. This failure resulted in Immediate Jeopardy, which was identified to have begun on 10/26/25 when the facility failed to prevent R1 from exiting the facility without staff knowledge and failed to put effective interventions in place to prevent a second occurrence on 3/6/26 when R1 and R2 exited the facility without staff knowledge. V3 (Senior Regional Administrator), V22 (Chief Executive Officer/CEO), and V7 (Regional Director of Clinical Services) were notified of the Immediate Jeopardy on 3/19/26 at 3:24 PM. The immediacy for both examples was removed on 3/20/26, but non-compliance remained at a Level Two because additional time is needed to evaluate the implementation and effectiveness of in-service training. Findings include:1. R1's admission Record documented an admission date of 9/5/25 and included diagnoses of dementia, osteoarthritis of knee, and hypertension. R1's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 07, indicating R1's cognition is severely impaired. Section E of this same MDS assessment, titled Wandering-Presence and Frequency documents this behavior occurred daily. R1's Care Plan documents a focus area of R1 is at risk for elopement related to dementia. R1 has a wander guard on but can remove it. It has been found on the bottom of her purse a couple of times (created 10/27/25). Interventions for this focus area include in part, 15-30 minute checks as needed (initiated 10/26/25 and revised 10/27/25), elopement on 10/26/25; 2nd wander guard attached to outside of her purse due to the fact she always carries her purse everywhere she goes, initiated 10/27/25 and revised on 11/3/25, R1 moved room closer to dining room for better observation, initiated on 10/28/25, revised 11/3/25, and resolved on 3/18/26, and elopement 2/6-staff educated that resident is at even higher risk for elopement when wearing makeup initiated 3/6/26. R1's Elopement/Wandering Risk Assessments dated 9/5/25 at 3:00 PM, 10/26/25 at 5:00 PM, 10/27/25 at 8:50 AM, and 1/25/26 at 9:39 AM all document R1 is at risk for elopement and wandering at this time. R1's document titled Risk Management dated 10/26/25 at 4:25 PM documents under nursing description This nurse was notified by another staff member that resident was brought back to facility with a police officer and that resident had eloped and was found wondering (sic) in town. Per administrator (V1), family stated resident was on (name of road which facility is located). Police officer left before speaking to this nurse. In the same document under Resident Description it documents Resident questioned and stated ?I just walked out the front door, I was going for a walk.' Resident was last seen two hours ago. and under Description of Action Taken it documents Bracelet in resident's pocket. Resident said she took her bracelet off when coming back into the building. Elopement bracelet immediately placed back on. Alarms to building and bracelet working effectively. Emergency contact, (V5/Family Member), aware of situation and spoke to resident. Head to toe assessment completed. No areas of concern. Resident denies any pain. 15 minute checks initiated. DON (Director of Nurses, V2) and administrator (V1) made aware. (V19, Physician) notified as well. Re-direct intervention: Have resident call emergency contact, (V5) for comfort. Interventions when exit seeking-offer snack, discuss knitting, offer to call family, sit with resident and let her talk/vent concerns and worries. Resident moved to room closer to dining room for better observation. R1's document titled Risk Management dated 3/6/26 at 11:30 AM documents under Nursing Description resident noted to be up the street pushing her friend to go look at cemetery, no s/s (signs/symptoms) of injury noted, resident brought back to facility in company van. Under Resident Description, it documents I was just going to show her my Mom and Dad's grave and under Description of Action (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Taken it documents resident noted to be up the street pushing her friend to go look at cemetery, no s/s of injury noted, resident brought back to facility in company van, assessed and brought back to facility per (name) another resident, they followed the smokers out and went the opposite direction. RCA (Root Cause Analysis)-confusion, thinks she is in community. Immediate intervention-staff educated that if resident is noted to be wearing makeup they should monitor for increased elopement risk. R1's Progress Note dated 10/26/25 at 4:25 PM, created by V4 (License Practical Nurse/LPN) documents This nurse was notified by another staff member that resident (R1) was brought back to facility with a police officer and that resident had eloped and was found wondering (sic) in town. Per administrator (V1), family stated resident was on (name of road where facility is located). Police officer left before speaking to this nurse. Resident questioned and stated I just walked out the front door, I was going for a walk. Resident was last seen two hours ago. Bracelet in resident's pocket. Resident said she took her bracelet off when coming back into the building. Elopement bracelet immediately placed back on. Alarms to building and bracelet working effectively. Emergency contact, (V5, Family Member) aware of situation and spoke to resident. Head to toe assessment completed. No areas of concern. Resident denies any pain. 15 minute checks initiated. DON (V2) and administrator (V1) made aware. (V19/Physician) notified as well. R1's Progress Note dated 10/26/25 at 5:00 PM, created by V1 documents This admin spoke with (V5), (V5) stated that they received a call regarding resident, she stated that resident was on (name of road where facility is located) when observed by police officer, let family know that resident had been placed on 15 minute checks and appeared to have no s/s of injury or emotional distress. Resident frequently worries about her money and sister stated when she visited earlier today that (R1) asked her to take her to the credit union. She reminded resident that she lived at (facility name) and that her family helps with her money. I asked sister for ideas for better redirection, she stated- offer snack, discuss what she is knitting, call sister or sister in law. Family coming to facility at 2 pm on 10/27/25 for careplan. R1's Progress Note dated 10/26/25 at 5:05 PM, created by V20 (Former Director of Nursing) documents Head to toe assessment complete. Skin intact with no issues noted. Resident voices no complaints of pain. Vitals 148/88, 97.9, 80, 20, O2 (oxygen) sats (saturation) 95% on room air. Resident states she is tired and just worn out from her walk today and just wants to lay down. Wander guard in place on right wrist and functioning properly. Resident lying in bed at this time no s/s of distress at this time. 15 min checks continue at this time. R1's Progress Note dated 10/27/26 at 3:50 PM, created by V1 documents spoke with dispatch regarding incident on 10/26/25, he stated that according to the officer the resident was on (name of road where facility is located) at approximately 1602 (4:02PM), taken to police station, family called, and resident was brought back to facility at 1620 (4:20PM). No distress was noted when they spoke with resident, she just wanted to call her sister in law. Per officer, resident was noted at church on (name of road where facility is located) and a pastor took her to police station when she couldn't remember the name of where she lived. R1's Progress Note dated 10/28/25 at 11:44 PM, created by V21 (Registered Nurse/RN) Resident continues on 15min (minute) checks. Resident in bed resting at this time. Resp (respirations) even and unlabored. no attempts to go out the door at this time. wandergaurd in place and working. Resident was moved to a room closer to the nurses station on day shift today. resident tolerating room change w/o (without) any issues at this time According to https://www.timeanddate.com/weather/@4237312/historic, on 10/26/25 the temperature in the city that the facility is located was 53 degrees Fahrenheit at 2:52 pm with a wind speed of 9 miles per hour and there was light rain with fog, and it was 54 degrees Fahrenheit at 3:52 pm with a wind speed of 10 miles per hour and there was light rain with an overcast. R1's Progress Note created by V1 (Administrator) on 3/18/26 at 11:32 AM with effective date of 3/6/26 at 11:32 AM documents Late Entry: Note Text: resident noted to be up the street pushing her friend to go look at cemetery, no s/s of injury noted, resident brought back to facility in company van, assessed and brought back to facility RCA (root cause analysis) - confusion, thinks she is in community Immediate intervention- staff educated that if resident is noted to be wearing makeup they should monitor for (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	increased elopement risk According to https://www.timeanddate.com/weather/@4237312/historic, on 3/6/26 the temperature in the city that the facility is located was 75 degrees Fahrenheit at 10:52 AM with wind speed of 16 miles per hour and it was 74 degrees Fahrenheit at 11:52 AM with wind speed of 21 miles per hour. According to https://google.com/maps, R1 traveled 0.5 miles from the facility to the location she was found by R1's family member on 3/6/26. Also, according to the website, the journey would take a minimum of 12 minutes on foot. 2. R2's admission Record documents an admission date of 9/11/25 and included diagnoses of anxiety disorder, chronic obstructive pulmonary disease, muscle weakness, cerebral atherosclerosis, primary hypertension, history of falling, metabolic encephalopathy, and osteoarthritis. R2's MDS assessment dated [DATE] documents a BIMS score of 04, indicating R2's cognition is severely impaired. R2's Care Plan documents R2 is at risk for elopement related to recent event with peer on 3/6/26 initiated on 3/6/26 and revised on 3/18/26. Corresponding interventions included in part elopement 3/6/26-educate staff R2 is at higher risk for elopement when wandering with R1. R2's Elopement/Wandering Risk Assessments dated 9/11/26 and 12/11/26 document R2 is not at risk for elopement or wandering at this time. R2's Elopement/Wandering Risk assessment dated [DATE] documents R2 is at risk for elopement or wandering at this time. R2's document titled Risk Management dated 3/6/26 at 11:30 AM documents under Nursing Description resident went with roommate on a ?walk,' no s/s of injuries noted. Under Resident Description, it documents I told her we should head on back and under Description of Action Taken it documents resident went with roommate on a ?walk' no s/s/ of injury noted. Per (name) another resident, they followed the smokers out and went the opposite direction. RCA-went for a walk with friend. Immediate intervention-resident educated to let staff know if roommate talks about going for a walk. R2's Progress Note created on 3/18/26 at 11:39 PM and effective 3/6/26 at 11:38 AM documents Late Entry: Note Text: resident went with roommate on a walk, no s/s of injuries noted RCA- went for a walk with friend. Immediate intervention- resident educated to let staff know if roommate talks about going for a walk According to https://www.timeanddate.com/weather/@4237312/historic, on 3/6/26 the temperature in the city that the facility is located was 75 degrees Fahrenheit at 10:52 AM with wind speed of 16 miles per hour, and it was 74 degrees Fahrenheit at 11:52 AM with wind speed of 21 miles per hour. According to https://google.com/maps, R2 traveled 0.5 miles from the facility to the location she was found by R1's family member on 3/6/26. Also, according to the website, the journey would take a minimum of 12 minutes on foot. On 3/18/26 at 10:11 AM, V5 (Family Member) said she was very upset over R1's elopement, stating something could have happened to her. V5 stated in October 2025, R1 left the facility without anyone knowing and no one knows how long she was gone. V5 stated R1 was found by a pastor and taken to the police station. V5 stated R1 didn't know where she lived but remembered her brothers phone number, so the police called him, and he told the police where she was living. V5 stated the police officer took R1 back to the facility and when she arrived back, they didn't even know R1 had been gone or how long she had been gone. Regarding the second incident, V5 stated that on 3/6/26 she was driving to the facility to see R1 and V5 saw her walking down the road pushing R2 in her wheelchair. V5 stated she thinks it was around 11:30 AM. V5 stated it was very windy that day. V5 stated they were on (name of street and business name approximately 0.5 miles away from the facility). V5 stated R1 was limping and told her that her foot and knee were hurting, and V5 stated R1 was exhausted looking and could hardly walk. V5 said she called V1 at the facility and V1 told her they didn't know R1 and R2 were gone. On 3/19/26 at 3:50 PM, the surveyor drove from the facility in the direction of the church/cemetery and local business where R1 and R2 were found on 3/6/26. The street is a striped, busy street that runs uphill for approximately 0.4 miles with no shoulder and no sidewalk observed until approximately the last 250 feet of the route. The next road, where R1 and R2 would have turned right to walk another 0.1 miles before being found by V5 is also a busy street with no shoulder and very little sidewalk. On 3/18/26 at 11:46 AM, R1 stated she left the facility a while back to go to the graveyard. R1 stated she didn't mean to make everyone mad when she left, she just (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	wanted to go see her mom and dad's [NAME]. R1 started crying during the interview so this surveyor changed the subject. R1 was alert to person only. On 3/18/26 at 2:46 PM, V1 stated R1 just walked out of the building in October, and she doesn't know why the wander guard didn't alarm. V1 stated she thinks R1 walked outside with the smokers on 3/6/26 because there was an alert and an oriented resident sitting in the hallway and she told V1 that R1 walked by her in the hallway pushing R2 towards the line of smokers waiting to go outside. V1 stated she doesn't know if the wander guard went off when she walked out of the door. V1 said when R1 returned to the facility, her wander guard bracelet was in her pocket. V1 stated R1 reported she took it off on the way back to the facility. V1 stated if the wander guard was in her left pocket instead of the right wrist it would not have alarmed because the scanner is only on the right side of the door. On 3/18/26 at 3:17 PM, R7 stated she was sitting in the hallway by her room door and R1 walked by pushing R2 on 3/6/26. R7 stated R2 asked her if she could go out with the smokers and R7 told R2 she would have to ask the staff member to take them out. She doesn't remember what time of day it was, but the smokers were lined up at the door around the corner. R7 stated she couldn't see the door from where she was sitting but she could see the end of the line of residents waiting to go outside on their smoke break. R7 stated R1 pushed R2 around the corner with the smokers, and she couldn't see where they went after they rounded the corner. R7 stated she never heard an alarm during that time, and she didn't see them walk out the door. On 3/19/26 at 2:13 PM, V14 (Power of Attorney/Family Member) stated he was not notified when R2 eloped from the building on 3/6/26. V14 stated he was told on 3/18/26 when he came to the facility for a care plan meeting. On 3/19/26 at 1:42 PM, V4 (Licensed Practical Nurse/LPN) stated she was working when R1 eloped on 10/26/25 and she did not know R1 was gone until the police brought her back. V4 stated she didn't know where R1 was found but the police said she was found uptown. V4 stated when R1 was brought back to the facility, she had her wander guard in her pocket, and the door should have alarmed when she left. V4 stated in October there was not a door alarm on the front door so if R1 went out that door it wouldn't have alarmed unless the wander guard was working properly. V4 stated there was a door alarm installed on the front door in December 2025. V4 stated when the police brought R1 back to the facility she was upset and hysterically crying. V4 stated it was raining that evening so R1's hair and clothes were wet from walking in the rain. V4 stated R1 didn't understand why the police had her, she thought she was in trouble. V4 stated R1 just didn't understand what was going on. V4 stated she called R1's sister to talk to her to try and help calm R1 down, then R1's sister ended up coming to the facility to see her to calm her down. V4 stated when R1 returned they did a head-to-toe assessment to make sure she didn't have any injuries, and no injuries were observed. V4 stated the CNA's (Certified Nurse Aides) said they saw R1 shortly after lunch when picking up her tray, then V4 said she saw R1 walk by her medication cart while she was passing medication in the hallway around 1:00 PM. V4 stated R1 was brought back around 4:25 PM on 10/26/25. V4 stated R1 was in a room near the nurses station when she eloped in October and then they moved her to a room further away from the nurses station and further away from the dining area, which is a common area, right before the elopement happed on 3/6/26. V4 stated she was working on 3/6/26 when R1 and R2 eloped. V4 stated no one knew they were gone until R1's sister called the facility and V1 called a code yellow. On 3/18/26 at 12:39 PM, V17 (Registered Nurse/RN) stated she was the nurse working R1 and R2's hall when they eloped on 3/6/26. V17 stated she doesn't know how they got out or how long they had been gone. V17 stated she did not notify the physician. On 3/18/26 at 12:30 PM, V1 stated the physician was not notified when R1 and R2 eloped on 3/6/26. On 3/18/26 at 12:19 PM, V19 (Physician) stated he was not notified of the incident on 3/6/26 involving R1 and R2. V19 stated he should have been notified. On 3/18/26 at 12:55 PM, V1 stated R1 was not moved closer to the dining room when they moved her just prior to her 3/6/26 elopement because they instead decided to put her in the room with R2 since they are good friends. V1 stated the intervention to move R1 closer to the dining room was left in the care plan until today, it was removed today. V1 stated an intervention in R1's care plan was added today for the elopement 3/6, stating (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	staff was educated that resident (R1) is at even higher risk for elopement when wearing makeup. On 3/18/26 at 12:58 PM, this surveyor requested the care plans for R1 and R2 after reviewing them in the electronic medical record. When reviewing R1's care plan in the electronic medical record, there was an intervention documenting R1 was moved to a room closer to the dining room for better observation, initiated on 10/28/25. When reviewing R2's care plan in the electronic medical record there was no documentation pertaining to elopement. V2 (Director of Nursing/DON) provided the care plans for R1 and R2 and this surveyor noticed R1's intervention documenting R1 being moved to a room closer to the dining room for better observation was no longer in the care plan. This surveyor questioned V2 about the intervention and she stated she deleted that intervention prior to printing out the care plan for this surveyor because R1 was never moved to a closer room. V2 stated she was going to go back into R1's care plan and put the intervention back in and resolve it the correct way then reprint it. After reviewing R2's printed care plan provided by V2 this surveyor noted a care area documenting R2 is at risk for elopement related to a recent event with peer on 3/6/26 that documented it was initiated on 3/6/26 and revised on 3/18/26. Corresponding interventions included in part elopement 3/6/26-educate staff R2 is at higher risk for elopement when wandering with R1. This surveyor asked V2 when those interventions were added and V2 stated she just put them in after the surveyor requested the care plan and back dated it to 3/6/26. On 3/19/26 at 10:28 AM, V24 (Activities Aide) stated she took the smokers out on 3/6/26 around 11:30 AM and she never saw R1 or R2 standing in the line or go out the door with them. V24 stated she stands at the door and holds it open for all the residents that come out for the smoke break and R1 and R2 did not come out with the rest of the residents. V24 stated when she started working at the facility on 2/18/26, she was told about the elopement book but not who was an elopement risk, and she has never looked at the book. V24 stated she still hasn't looked at the elopement book, but she will look at it today. On 3/19/26 at 10:38 AM, V25 (Maintenance Director) stated he has never done any maintenance or checking of the wander guard system, adding he doesn't know anything about it. V25 stated every outside door has an alarm on it. At this time, V25 was observed checking each exit door. There were 6 doors leading outside. The dining room door was alarmed with a pull alarm that was tied around the top hinge of the door and it pulled apart when the door opened. V25 did not know how to shut the alarm off. There was a resident sitting in the dining room that was yelling to V25 telling him how to shut the alarm off. V6 (Assistant Director of Nursing/ADON) then came and showed V25 how to shut it off by reconnecting the pull tab. The door down the hallway next to the kitchen was alarmed with a keypad. The door on hall A had an alarm that required a key to shut it off, but it shuts off automatically after 30 seconds if the key isn't used, V25 stated only the nurse for this hallway and V26 (BOM) have a key for this door. The door near the therapy department was alarmed with a push button to shut it off. The door at the end of hall B had an alarm that required a key to shut it off, or it automatically stops alarming after 30 seconds if the key is not used. V25 stated only the nurse for this hallway and V26 have a key to this door. V25 stated he checks the alarms monthly. On 3/19/26 at 10:38 AM, this surveyor asked V25 for the log documenting the monthly door alarm maintenance. V25 stated he doesn't know of one as he has only done it once this month because he just started working at the facility. On 3/19/26 at 10:57 AM, V1 had a wander guard in her hand, opened the front door and the door alarm sounded when she opened it. R1 walked out the door with the wander guard in her hand then walked back in the door. The door alarm continued the whole time but there was never an additional alarm when V1 walked out the door with the wander guard. V1 then put the door code in and walked back out the door with the wander guard, then walked back in the door and no alarm sounded. V1 stated she isn't sure why they use the wander guard as an elopement intervention because a door alarm was installed on the front door in December of 2025. Now the door alarms when it is opened if the code is not entered. V1 stated she requested today to stop using the wander guard system since it doesn't work properly. On 3/19/26 at 11:06 AM, V1 stated the wander guard system is only on 1 of the 6 exterior doors, the front door. V1 stated there isn't any maintenance or checking of the wander guard system that is on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	the front door. V1 stated the company they get the wander guards from will call them when the wander guard band that is on the resident is starting to go bad and tell them it needs changed. V1 stated they have a small portable box the nurses use to check the wander guard bands on the residents who wear them, and this is supposed to be done daily. V1 stated as far as she knows it gets done daily. V1 stated the front door previously did not have a door alarm and when they put one on it in December 2025, it was hard wired in with the wander guard system so when the door alarm is shut off, it also disables the wander guard system. V1 stated she doesn't know if there is a log for the maintenance checks on the door alarms because the former maintenance director is no longer working at the facility and he oversaw checking door alarms. On 3/30/26 at 8:40 AM, V1 provided this surveyor with documents titled (Corporate Name) Door Alarm Checks dated November 2025, December 2025, January 2026, February 2026, and March 2026. The documents have Yes checked for each day of the month with V1's initials. V1 stated she did the door checks because she wasn't sure if the former maintenance director was doing them. This surveyor asked her if she was the one doing the door checks and she stated yes. After being asked to clarify if V1 came into the facility every day including weekends to complete the door alarm checks, V1 stated the manager on duty was actually doing them and she just signed them off. This surveyor asked V1 why on 3/19/26 at 11:06 AM she stated she didn't know if they were being done and V1 stated she must have just forgotten. On 3/19/26 at 11:10 AM, the surveyor asked V2 (DON) to check each residents wander guard band with the alarm system on the door. V2 walked each of the residents through the doors that were agreeable to do it and none of the wander guards alarmed. The door alarmed when opened and the alarm shut off when the door code was entered, but when walking the residents with the wander guard bands on out the door, it did not alarm. The following residents wander guards were checked: R8 (wander guard on left wrist), R9 (wander guard on right wrist), R1 (wander guard on right wrist), R10 (wander guard on right wrist), R11 (wander guard on right wrist), R12 (wander guard on right wrist), R13 (wander guard on right wrist), and R14 (wander guard on right wrist). On 3/19/26 at 11:33 AM, R1 emptied her purse with V1, and this surveyor present to look for the wander guard that was supposed to be put in her purse as a elopement intervention. R1 emptied her entire purse onto a table with this surveyor and V1 observing and V1 stated the wander guard was not in the purse. This surveyor did not observe the wander guard in the purse or in the belongings on the table. V1 asked V10 (Activities Director) to get bags to help organize R1's purse. V10 came back and bent down in front of the belongings out of R1's purse. V1 bent down beside her and whispered to V10 then stood up with a wander guard band in her hand and stated she found the wander guard in the pile of belongings. On 3/18/26 at 12:48 PM, V13 (CNA) stated she was just now educated today to watch for R1 wearing makeup as an intervention for her elopement risk. V13 stated she hasn't been educated on anything regarding R2 being an elopement risk. On 3/18/26 at 11:54 AM, V15 (CNA) stated she was not educated to watch for R1 to be wearing makeup or anything regarding her purse. On 3/18/26 at 11:59 AM, V16 (CNA) stated she started working at this facility about 2 months ago. V16 stated she was working when R1 and R2 eloped on 3/6/26 and she didn't know they were gone until they came back. V16 stated she wasn't educated on anything directly related to R1 or R2 after their elopement. On 3/18/26 at 12:27 PM, V6 (ADON) stated she knows R1 and R2 eloped, but she doesn't remember if she was working on 3/6/26 and she remembers being educated on something regarding the incident, but she doesn't remember what the education was. A facility policy titled Elopements dated 2026 documents under Policy Interpretation and Implementation, 3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: b. Notify the Attending Physician, c. Notify the residents legal representative (sponsor) of the incident, d. Document the notifications and exam in the resident's medical record. A facility policy titled Safety and Supervision of Residents dated 3/2026 documents under Individualized, Resident-Centered Approach to Safety, 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff, c. providing training, as necessary, d. ensuring that interventions are implemented and (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	e. Documenting interventions. In the same documents under Systems Approach to Safety, 4. As part of the facility elopement prevention, when taking residents outside for their supervised smoking times the following three head counts will be conducted, a. Head count upon exit from the building, b. Head count upon arrival at designated smoking area, and c. Head count upon re-entry to the facility. The Immediate Jeopardy that began 10/26/25 was removed on 3/20/26 when the facility took the following actions to remove the immediacy: R1 is safe and on 15-minute visual checks. R1 will remain on these checks indefinitely.R2 is safe and on 15-minute visual checks. R2 will remain on these checks until IDT determines the checks are no longer warranted through ongoing assessment, monitoring, and care plan review.Facility has reviewed the following policies for education and implementation, Elopement Policy and Safety/Supervision of Residents to include head counts for supervised smoking as a systems approach to safety.V1 immediately checked all exit doors for alarm function. All alarms are functioning and require a key and/or code to shut them off.V1 immediately did a resident head count to assure all residents accounted for. All residents were accounted for.V1 contacted R1's responsible party about sending referrals to locked dementia/Alzheimer units within the state as this would be the safest environment for R1.Facility has placed Stop Sign door guards at each exit door with the exception of the front lobby door where visitors and staff enter and exit many times a day. Staff are being educated to not remove the door guards. No one will work without receiving the education first.V3 (Regional Senior Administrator) placed a sign at the front lobby exit door asking all visitors to please make sure no one exits the facility with them and that the door closes completely behind them.Wander guards will not be used as an elopement prevention intervention on care plans going forward. The system was only applicable to the front door. The facility switched to a door alarm that sounds every time the door opens without a code being entered and stays sounding until a code is entered on 12/9/2025. The wander guard system on this door used the same audible alarm sound that the constant door alarm now does. All exit doors in the facility are alarmed every time a door opens regardless of who is going in or out since 12/9/2025. This is much safer than having the front lobby door only equipped with a wander guard system. The wander guard was proven to be ineffective for elopement prevention because of individual resident placement and/or removal. Care plans are being updated to reflect the change. Physician and responsible parties are being notified of same.The facility will increase the frequency of the Elopement/Alarm Drill Protocol from monthly to weekly for the next four weeks. The Elopement/Alarm Drill Protocol includes instruction and teaching on how the staff respond to alarms and the steps to follow when responding to an alarm. Director of Nursing, Maintenance Director, MDS Coordinator, Social Service Director, Regional Senior Administrator, Regional Director of Clinical Services, and Activity Director will be educated by the Administrator on the following policies and procedures, Elopement Policy and Safety Supervision Residents policy.Prior to working next scheduled shift until all employees are educated. Train the trainer has been completed so this training will be conducted by either the Administrator or an IDT (interdisciplinary) team member who has been trained by the Administrator to conduct such training.All department new hires will be educated prior to starting any shifts by a member of the IDT that has been trained to provide the training.Resident elopement risk assessments on all residents are being reviewed for accuracy.All resident elopement risk care plan audit initiated to assure all interventions are in place and implemented according to plan of care.Clinical staff will be educated upon hire on the following policies and content; Elopement Policy and

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to pass water to 4 of 4 residents (R4, R7, R21, R22) reviewed for hydration in a sample of 25. Findings include:1. R4's admission Record documented an admission date of 8/12/25 and included diagnoses of chronic obstructive pulmonary disease, type 2 diabetes, muscle weakness, primary hypertension, and atherosclerotic heart disease of native coronary artery. R4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. R4's Order Summary Report documents Furosemide oral tablet 20 milligrams (mg), give one tablet by mouth in the morning related to primary hypertension. R4's Care Plan documents R4 has potential/actual impairment to skin integrity related to fragile skin (initiated 8/22/25) with a corresponding intervention to encourage good nutrition and hydration to promote healthier skin (initiated 8/22/25). On 3/19/29 at 9:29 AM, R4 did not have water in his room. R4 stated he doesn't get water very often and he likes to have water to drink because sometimes he gets thirsty. On 3/30/26 at 8:55 AM, R4 did not have water in his room. R4 stated sometimes someone brings him water but not every day. On 4/13/26 at 2:15 PM, R4 stated no one has filled his water cup up today. R4 stated there is a little bit of water left in his cup, but it is old and warm. On 4/2/26 at 11:35 AM, V27 (Family Member/Power of Attorney-POA)stated every time she would visit R4 he wouldn't have water in his room. Therefore, she brought a cup in for R4 so they could fill it with water and still a lot of the time she goes to see him, the cup still doesn't have water in it. 2. R21's admission Record documented an admission date of 2/19/26 and included diagnoses of dehydration, muscle wasting and atrophy, urinary tract infection, and adult failure to thrive. R21's MDS assessment dated [DATE] documented a BIMS score of 12, indicating moderate cognitive impairment. Dehydration is listed in the Active Diagnoses section of this MDS. Under Care Area Assessment Summary Dehydration/Fluid Maintenance is checked as a triggered care area. R21's Care Plan documents R21 has potential/actual impairment to her skin integrity related to chronic disease processes (initiated 2/20/26) with a corresponding intervention to encourage good nutrition and hydration to promote healthier skin (initiated 2/20/26). On 4/13/26 at 1:52 PM, R21 stated she doesn't get water passed every day. R21 stated she was admitted to the hospital with dehydration prior to her admission to the facility, so it is important she drinks enough water every day. R21 stated when she was first admitted to the facility, she never got water passed to her, so her daughter had to start bringing her water, stating she comes by almost every day with a fresh cup of ice water. R21 stated the facility is so short staffed on CNA's (Certified Nurse Aides) that she hates having to ask for water because she knows they don't have enough CNA's to do everything. V36 (Family Member) was present during this interview and stated there was an issue with R21 not getting anything to drink during the day so V36 started bringing R21 water to the facility. 3. R7's admission Record documented an admission date of 8/15/25 and included diagnoses of urinary tract infection, chronic obstructive pulmonary disease, emphysema, chronic kidney disease, and disorders of kidney and ureter. R7's MDS assessment dated [DATE] documented a BIMS score of 14, indicating intact cognition. R7's Care Plan documents R7 has impaired skin integrity related to age related changes, chronic disease processes, incontinence, and deconditioning (initiated 8/22/25) with a corresponding intervention to encourage good nutrition and hydration to promote healthier skin (initiated 8/22/25). R7's Order Summary Report documents R7 was referred to urology related to frequent urinary tract infections on 1/15/26. On 3/25/26 at 9:59 AM, R7 stated she doesn't get water passed to her every day and she wishes they would. R7 stated she likes having water to drink during the day. R7 stated she asks for water sometimes and they do get it, but only when she asks. R7 stated they shouldn't have to ask for water, adding what happens to the residents that can't ask? On 4/6/26 at 9:25 AM, R7 stated they don't pass fresh water to her every day, stated the water she has now is from the night before when she asked someone to get her (continued on next page)

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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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a drink. R7 stated the CNA's tell her they are short staffed often, so she thinks that is why they don't pass water every day. On 4/6/26 at 1:16 PM, R7 still did not have a cup of water in her room and stated she hasn't gotten any water passed to her today. 4. R22's admission Record documented an admission date of 8/29/25 and included diagnoses of muscle wasting and atrophy, muscle weakness, and fatigue. R22's MDS assessment dated [DATE] documented a BIMS score of 15, indicating intact cognition. R22's Care Plan documents R22 has potential impairment to her skin integrity related to limited mobility (initiated 9/2/25) with a corresponding intervention to encourage good nutrition and hydration to promote healthier skin initiated 9/2/25. On 4/6/26 at 9:28 AM, R22 did not have a cup of water in her room. R22 stated occasionally someone will bring her water to her room, but not very often. R22 stated sometimes she gets thirsty and would like a cup of water. On 4/6/26 at 1:25 PM, R22 still did not have a cup of water in her room. R22 stated no one has brought her water all day. On 4/13/26 at 2:10 PM, R22 did not have a cup of water in her room. R22 stated no one has brought her any water to her room today. On 3/23/26 at 3:20 PM, V12 (Helping Hand) stated water is supposed to be passed once in the morning and once in the afternoon. V12 stated she is still in school, so she doesn't come in until 3:00 PM during the week and a lot of the time water hasn't been passed for the day yet because there aren't enough CNA's to properly care for the residents and pass water. V12 stated when she gets to the facility, V2 (Director of Nursing/DON) usually tells her she needs to pass water because the CNA's haven't had time to pass water yet. On 3/31/26 at 1:31 PM, V30 (Registered Nurse/RN) stated she sees water isn't passed to residents every day due to not having enough CNA's to do it. On 4/13/26 at 2:24 PM, V1 (Administrator) stated water should be passed in the morning around 7:00 AM to 10:00 AM, again in the afternoon, and again around 7:00 PM to 10:00 PM. V1 said then the night shift picks all the cups up around 4:00 AM to 5:00 AM and takes them to the kitchen for them to be washed so the day shift can get them again for that morning. On 4/16/26 at 12:00 PM, V1 stated the facility does not have a policy related to hydration and passing water to residents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a sufficient amount of staff to meet the needs of the residents in a timely manner. These failures have the potential to affect all 67 residents living in the facility. Findings include:1. R4's admission Record documented an admission date of 8/12/25 and included diagnoses of chronic obstructive pulmonary disease, type 2 diabetes, muscle weakness, primary hypertension, atherosclerotic heart disease of native coronary artery, other fatigue, abnormal findings on diagnostic imaging of lung, and bilateral hearing loss. R4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. R4's Order Summary Report documents a referral to oncology due to abnormal results from CT (Computed Tomography, diagnostic imaging procedure) of the abdomen and abnormal results of x-ray of left shoulder with an order date of 1/30/26, stat referral to interventional radiology for guided pulmonology biopsy with an order date of 3/11/26, and an urgent referral to pulmonology related to CT results and oncology request with an order date of 3/6/26. On 3/19/26 at 9:29 AM, R4 stated he has constant pain in his back, chest, and left arm/shoulder. R4 stated he was told he had cancer that was spreading and that is why he is having pain. R4 stated he keeps being told they are trying to get him an appointment for his cancer, but he still hasn't been to the doctor. R4 stated he isn't sure if they are even doing anything to help him. R4 stated he wants to get treatment for his cancer. On 3/30/26 at 2:29 PM, V6 (Assistant Director of Nursing) stated R4 was admitted with a lesion on his lung. V6 stated in January 2026, R4 began complaining of abdominal pain and he had an x-ray that showed bowel gas; then on 1/29/26, R4 had a CT of the abdomen, and it showed some lesions so V19 ordered a referral to oncology on 1/30/26 and it was faxed on that day. V6 stated the previous director of nursing called and checked on the referral on 2/4/26 and re-faxed it then. V6 stated no one called to check on the referral until 2/23/26 when V4 (Licensed Practical Nurse/LPN) called and re-faxed the referral. V6 stated on 3/6/26 she received a call from oncology stating R4 needed to see pulmonology and needed a biopsy before they could see R4, so V6 faxed an order per V19 (Physician) to pulmonology for a referral. V6 stated she received a phone call on 3/11/26 from V19's office stating V19 wanted a referral sent to interventional radiology for R4 to get a biopsy, so V6 faxed an order to them. V6 stated on 3/18/26 she called interventional radiology to see if they received the referral and they told V6 they couldn't do the biopsy because they didn't have the correct imaging and told V6 to call (outside radiology company) to see what else V6 needed to send. V6 stated she called and spoke with V29 (Interventional Radiology Clinical Coordinator), and V6 was told to send the records, and V29 would look at it and let V6 know what they needed. V6 stated at that time the facility was short staffed, and V6 was working on the floor everyday as a CNA (Certified Nurse's Aide) so she passed the referral information for oncology and interventional radiology off to V1 (Administrator) and V2 (Director of Nursing) but V6 forgot about the referral to pulmonology so that was never followed up on. V6 stated she forgot to follow up with V29 as well to see what they needed. V6 stated R4 had an appointment scheduled for 3/2/26 to see an orthopedic doctor for the fracture in his left arm but he did not go to it because they were short staffed and there wasn't anyone to take him. V6 stated they didn't call and reschedule the appointment, they no showed to the appointment, and it hasn't been rescheduled yet that V6 knows of. V6 stated she hasn't done anything else at this point with the referrals and as far as she knows, as of today R4 does not have an appointment with oncology, pulmonology, orthopedics, or had a biopsy. 2. On 4/16/26 at 11:01 AM, V4 (LPN) observed R4's toenails with this surveyor present. R4's toenails were long and wrapping around the end of his toes, extending to underneath of his toes. V4 stated R4's toenails needed trimmed, and she doesn't know why they haven't been trimmed. V4 stated they used to have a podiatrist come to the facility, but they don't have one that (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	comes to the facility anymore. R25's admission Record documented an admission date of 9/8/22 and included diagnoses of type 2 diabetes, Alzheimer's disease, muscle weakness, and need for assistance with personal care. R25's MDS assessment dated [DATE] documented a BIMS score of 07, indicating severe cognitive impairment. R25's Care Plan documents R25 has an ADL (Activities of Daily Living) self-care performance deficit related to weakness and requiring assistance with ADL's. On 4/16/26 at 11:15 AM, V4 observed R25's toenails with this surveyor present. R25's toenails were thick and needed trimmed. V4 stated she wouldn't feel comfortable trimming R25's toenails due to the thick growth of the nails and stated R25 needs a podiatry referral. R11's admission Record documented an admission date of 12/27/22 and included diagnoses of type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, borderline intellectual functioning, and muscle weakness. R11's MDS assessment dated [DATE] documented a BIMS score of 13, indicating intact cognition. On 4/16/26 at 11:08 AM, V4 observed R11's toenails with this surveyor present. R11's toenails were long and V4 stated they needed trimmed. R11 stated her toes are painful and her toenails need trimmed. On 4/16/26 at 12:02 PM, V6 (ADON) stated the nurses oversee trimming toenails for diabetic residents but it always ends up being her because the nurses don't do it and she hasn't had time to trim toenails due to being short staffed. 3. On 3/19/29 at 9:29 AM, R4 did not have water in his room. R4 stated he doesn't get water very often and he likes to have water to drink because sometimes he gets thirsty. On 3/30/26 at 8:55 AM, R4 did not have water in his room. R4 stated sometimes someone brings him water but not every day. On 4/13/26 at 2:15 PM, R4 stated no one has filled his water cup up today. R4 stated there is a little bit of water left in his cup, but it is old and warm. On 4/2/26 at 11:35 AM, V27 (Family Member/Power of Attorney-POA) stated every time she would visit R4 he wouldn't have water in his room. Therefore, she brought a cup in for R4 so they could fill it with water and often when she visits, the cup still doesn't have water in it. R21's admission Record documented an admission date of 2/19/26 and included diagnoses of dehydration, muscle wasting and atrophy, urinary tract infection, and adult failure to thrive. R21's MDS assessment dated [DATE] documented a BIMS score of 12, indicating moderate cognitive impairment. R21's Care Plan documents R21 has potential/actual impairment to her skin integrity related to chronic disease processes (initiated 2/20/26) with a corresponding intervention to encourage good nutrition and hydration to promote healthier skin (initiated 2/20/26). On 4/13/26 at 1:52 PM, R21 stated she doesn't get water passed every day. R21 stated she was admitted to the hospital with dehydration prior to her admission to the facility, so it is important she drinks enough water every day. R21 stated when she was first admitted to the facility, she never got water passed to her, so her daughter had to start bringing her water, stating she comes by almost every day with a fresh cup of ice water. R21 stated the facility is so short staffed on CNA's (Certified Nurse Aides) that she hates having to ask for water because she knows they don't have enough CNA's to do everything. V36 (Family Member) was present during this interview and stated there was an issue with R21 not getting anything to drink during the day so V36 started bringing R21 water to the facility. R7's admission Record documented an admission date of 8/15/25 and included diagnoses of urinary tract infection, chronic obstructive pulmonary disease, emphysema, chronic kidney disease, and disorders of kidney and ureter. R7's MDS assessment dated [DATE] documented a BIMS score of 14, indicating intact cognition. R7's Care Plan documents R7 has impaired skin integrity related to age related changes, chronic disease processes, incontinence, and deconditioning (initiated 8/22/25) with a corresponding intervention to encourage good nutrition and hydration to promote healthier skin (initiated 8/22/25). On 3/25/26 at 9:59 AM, R7 stated she doesn't get water passed to her every day and she wishes they would. R7 stated she likes having water to drink during the day. R7 stated she asks for water sometimes and they do get it, but only when she asks. R7 stated they shouldn't have to ask for water, adding what happens to the residents that can't ask? On 4/6/26 at 9:25 AM, R7 stated they don't pass fresh water to her every day, stated the water she has now is from the night before when she asked someone to get her a drink. R7 stated the CNA's tell her they are short staffed (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	often, so she thinks that is why they don't pass water every day. On 4/6/26 at 1:16 PM, R7 still did not have a cup of water in her room and stated she hasn't gotten any water passed to her today. R22's admission Record documented an admission date of 8/29/25 and included diagnoses of muscle wasting and atrophy, muscle weakness, and fatigue. R22's MDS assessment dated [DATE] documented a BIMS score of 15, indicating intact cognition. R22's Care Plan documents R22 has potential impairment to her skin integrity related to limited mobility (initiated 9/2/25) with a corresponding intervention to encourage good nutrition and hydration to promote healthier skin initiated 9/2/25. On 4/6/26 at 9:28 AM, R22 did not have a cup of water in her room. R22 stated occasionally someone will bring her water to her room, but not very often. R22 stated sometimes she gets thirsty and would like a cup of water. On 4/6/26 at 1:25 PM, R22 still did not have a cup of water in her room. R22 stated no one has brought her water all day. On 4/13/26 at 2:10 PM, R22 did not have a cup of water in her room. R22 stated no one has brought her any water to her room today. On 3/23/26 at 3:20 PM, V12 (Helping Hand) stated water is supposed to be passed once in the morning and once in the afternoon. V12 stated she is still in school, so she doesn't come in until 3:00 PM during the week and a lot of the time water hasn't been passed for the day yet because there aren't enough CNA's to properly care for the residents and pass water. V12 stated when she gets to the facility, V2 (Director of Nursing/DON) usually tells her she needs to pass water because the CNA's haven't had time to pass water yet. 4. R6's admission Record documented an admission date of 3/2/22 and included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, morbid obesity, cystitis, weakness, and polyarthritis. R6's MDS assessment dated [DATE] documented a BIMS score of 12, indicating moderately impaired cognition. On 3/19/26 at 9:41 AM, this surveyor observed R6's call light already activated. During continuous observation, this surveyor observed V10 (Activities Director) go into R6's room. V10 did not ask R6 if she needed anything, then left room and the call light remained on. R6 stated to this surveyor, she needed to be cleaned up, she was incontinent. At 9:57 AM, V38 (Medical Records) came into the room and asked R6 if she needed something and she said she needed cleaned up. V38 said she would go get someone to help R6. At 10:00 AM, V15 and V23 (both CNA's) came into R6's room to clean her up. V15 stated she is the only one on this hallway and she is training V23 because it is her first day. R24's admission Record documented an admission date of 7/16/25 and included diagnoses of anxiety disorder, chronic kidney disease, and essential tremors. R24's MDS assessment dated [DATE] documented a BIMS score of 11, indicating moderate cognitive impairment. R24's Care Plan documents R24 is a fall risk (initiated 8/22/25) with corresponding interventions to be sure R24's call light is within reach and encourage R24 to use it for assistance as needed. R24 needs prompt response to all requests for assistance (initiated 8/22/25). On 3/31/26 at 1:35 PM, R24's call light was observed to be already activated at 1:35 PM. R24 stated she was needing someone to bring her an (adult brief) because she had been incontinent. Continuous observation revealed the call light to be answered by V6 (ADON) at 1:56 PM. R24 stated she always has a long wait when she puts her call light on. R24 stated she usually has to wait at least 20 minutes. V6 stated she got to R24 as quickly as she could, but they had more CNA's (Certified Nursing Aides) call in today and she was working the floor to help. On 4/20/26 at 9:46 AM, V7 (Regional Director of Clinical Services) stated they do not have a policy related to call lights. On 4/21/26 at 1:23 PM, V1 (Administrator) confirmed they do not have a policy related to call lights that she is aware of. V1 stated anyone can answer call lights so she would hope that within 15 minutes max that someone has answered the call light. 5. R18's admission Record documented an admission date of 6/5/24 and included diagnoses of Parkinson's disease, dementia, muscle weakness, and other lack of coordination. R18's MDS assessment dated [DATE] documented a BIMS score of 05, indicating severely impaired cognition. R18's Care Plan documents an ADL self-care performance deficit related to dementia, Parkinson's, and impaired balance with generalized weakness initiated 6/7/24. On 3/25/26 at 2:43 PM, this surveyor observed facial hair on R18's face and asked R18 if the staff shave his face. R18 stated well, as you can see, they haven't and stated he (continued on next page)

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 04/22/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	doesn't like having facial hair. R19 (R18's roommate/family member) stated they only have one girl at the facility that can shave so (R18) has to wait until she has time. On 3/31/26 at 1:31 PM, V30 (Registered Nurse/RN) stated she doesn't think there are enough CNA's to properly care for the residents. V30 stated she gets complaints from residents that they have to wait to be cleaned up after being incontinent and she sees beds are not being stripped and clean linens put on due to not having enough CNA's. V30 stated water isn't passed to residents every day either due to not having enough CNA's to do it. On 4/16/26 at 11:58 PM, V39 (CNA) stated she thinks staffing is better now but there were a couple of times she worked with only 2 CNA's in the building. V39 stated a few weeks ago on a weekend there were only 2 CNA's for most of the day. On 4/16/26 at 12:00 PM, V1 (Administrator) stated they do not have a policy related to staffing. The facilities Daily Census report dated 3/18/26 documents 67 total residents living in the facility.

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 04/22/2026
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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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure quarterly Quality Assurance meetings were held and failed to ensure the Medical Director attended the Quality Assurance meetings. This failure has the potential to affect all 67 residents residing in the facility. Findings include:The facility's Quality Assurance Meeting Sign-in List and Minutes dated 1/23/25, 3/13/25, 7/30/25, and 1/9/26 did not document a signature from the facility's medical director affirming the medical director's attendance. On 3/24/26 at 11:20 AM, V1 (Administrator) stated they did not have a QAPI (Quality Assurance and Performance Improvement) meeting for the 4th quarter in 2025. V1 stated they only had one in January 2025, March 2025, and July 2025 in 2025. V1 stated the medical director has never attended the QAPI meetings. On 4/13/26 at 3:00 PM, V1 stated they do not have a policy related to quarterly quality assurance meetings, but they are to be held quarterly, and the medical director should be in attendance. The facility Daily Census report dated 3/17/26 documented there were 67 residents residing in the facility.

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	146006	A. Building B. Wing	04/22/2026

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Integrity Hc of Anna	315 South Brady Mill Road Anna, IL 62906

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, the facility failed to ensure staff were trained on effective communications. This has the potential to affect all 67 residents currently residing at the facility. Findings include:On 3/24/26 at 11:00 AM, staff training in-services provided to this surveyor by V1 (Administrator) were reviewed. Training subjects that were missing included communication, behavioral health, and nursing aide annual required training. On 3/24/26 at 12:50 PM, V7 (Regional Director of Clinical Services) stated he was only able to find staff training on QAPI (Quality Assurance and Performance Improvement), infection control, resident rights, and abuse. V7 stated he was unable to find any staff training on communication, compliance and ethics, behavioral health, and any nursing aide required training. On 3/24/26 at 1:00 PM, V1 (Administrator) stated the staff have not been trained on communication, behavioral health, and the nurses' aides have not received their required number of annual training hours. V1 stated she wasn't aware those were required. On 4/13/26 at 3:00 PM, V1 stated they do not have a policy related to staff training. The facility Daily Census report dated 3/17/26 documented there were 67 residents residing in the facility.