

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/31/2026
NAME OF PROVIDER OR SUPPLIER Integrity Hc of Anna		STREET ADDRESS, CITY, STATE, ZIP CODE 315 South Brady Mill Road Anna, IL 62906	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review, the facility failed to ensure meals were served at regularly scheduled times in accordance with resident needs/preferences. This has the potential to affect all 64 residents residing in the facility. On 7/23/2026 at 8:50AM, R9 was asked how her meals are and R9 stated well they are late sometimes and supper is usually always late. R9 said it has been as late at 8:00PM when she has gotten a supper tray. On 7/23/2026 at 8:56AM, R10 stated she usually eats her meals in the dining room. R10 stated if she eats on the halls then the meals are always late. On 7/24/2026 at 5:40PM, the supper meal was observed, and the first tray was served out at 5:45PM. On 7/24/2026 at 5:45PM, the mealtimes were observed posted in the Dining Room and documented that Breakfast is at 7:30AM, Lunch is at 12:00PM and Dinner is at 5:30PM. On 7/24/2026 at 7:00PM, R3 and R4 were in their shared room and received their supper trays. R3 and R4 received their trays which included bologna sandwiches and soup. R4 took a bite of the soup and said, I don't like this. R4 was asked if he wanted something else to eat and R4 stated no I will just eat it because it is already too late to eat supper and I am hungry. R3 was asked if he was satisfied with his meal and R3 stated I am going to eat it because I want something to eat now. On 7/24/2026 at 7:10PM, R10 received her supper tray. R10 refused her tray and stated, I am not hungry now, so I don't want it. R10 told staff to take the tray back out of her room so staff did as R10 requested. R10's was the last tray to be served for this meal. On 7/24/2026 at 7:15PM, V1 (Administrator) was asked if she could explain why the supper meal was so late as it had been 1 hour and 40 minutes since they were supposed to receive the meal. V1 stated it has been an ongoing issue, she knows it is not acceptable, but they need to get people replaced in the kitchen to solve the problem. On 7/28/2026 at 8:15AM, this surveyor entered the facility and observed breakfast being served. On 7/28/2026 at 8:55AM, R2 was in her room sitting on the side of her bed beginning to eat breakfast. R2 stated I just got my food and I am hungry. R2 was asked if she normally eats breakfast about this time of morning and R2 stated it is always late, but I am sure glad to get it because I am hungry in the mornings. On 7/28/2026 at 9:00AM, R3 and R4 received their breakfast trays in their shared room. R3 stated our meals are always late. R3 stated we eat it when we get it but sometimes it is just too late at night to eat. On 7/28/2026 at 9:05 AM, V14 (Licensed Practical Nurse/LPN) stated meals are late on certain days, it just depends on the day. On 7/28/2026 at 9:10AM, the last breakfast tray was observed being served to R9. On 7/28/2026 at 9:20AM, R9 stated I just got my breakfast a few minutes ago, but this is normal and it is not unusual for supper to be late, and I mean getting supper at 8:00PM at night. On 7/28/2026 at 11:13 AM, V16 (Cook) stated the reason breakfast was so late this morning is because the night shift from yesterday did not clean up and do dishes so we had to do that before we could start cooking. V16 stated supper is late very often and that is due to staffing. V16 stated she is (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	working over today, and supper will be on time for sure tonight. On 7/28/2026 at 11:20AM, V17 (Dietary Aide/Cook) stated meals are late, especially at supper. V17 stated we are working on getting staff, we are short on cooks, aides, and a manager. V17 stated I have worked here for many years, and this is the worse I have ever seen this kitchen. On 7/28/2026 at 11:30AM, V1 (Administrator) stated I just hired a part time person for the kitchen and I have recently hired a few other kitchen staff, so we are trying to get good staff to get all of this straightened out. On 7/28/2026 at 11:33AM, V11 (CNA) stated the meals are not always late but it has become more often lately. V11 stated she thinks breakfast was late this morning due to meal cards not being ready on time. V11 stated the residents do complain when the meals are late and they are on their call lights asking where their trays are. On 7/28/2026 at 11:36AM, V9 (CNA) stated late meals are kind of a pattern and depend on who is working in the kitchen. The residents do complain about their meals being served late. The Facility's Midnight Census Report dated 7/22/26 documents 64 residents residing in the facility.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the resident and resident representative written notification of transfer and Bed-Hold Policy information at the time of transfer or as soon as practicable for 1 (R1) out of 3 residents reviewed for discharge process in the sample of 13. Findings Include: R1's admission Record documented an admission date of [DATE], a discharge date of [DATE], and included diagnoses of generalized anxiety disorder, hypothyroidism, hyperlipidemia, depression, lack of coordination, muscle weakness, and schizophrenia. R1's admission Record documents R1 as Responsible Party but also lists V4 (Office of State Guardian/OSG Representative) as R1's Guardian. R1's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R1's cognition is intact. R1's Progress Note dated [DATE] at 4:19 PM documents R1 became agitated over not calling her OSG rep. (V4) from OSG does not want resident to call more than two times per day and R1 had already called several times and became extremely agitated, began calling staff racial slurs, telling staff she hoped that their baby died and continued to curse in hall, Sheriff's department was notified and arrived at building at approximately 1640 (4:40 PM) and took resident to ER (emergency room) for psych eval. R1's Progress Note dated [DATE] at 4:43 PM documents V4 (OSG Representative) attempted to be notified of R1 going to ER for eval related to behaviors. No answer received and message left. R1's Progress Note dated [DATE] at 12:46 AM documents RN (Registered Nurse) from the local hospital ER notified the facility that R1 would be transferring to an in-state behavioral health/psychiatric hospital (located approximately 5 hours away) on this date and is awaiting transport at this time and will notify facility when transport arrives. R1's Progress Note dated [DATE] at 7:00 AM documents R1 was being transferred to the in-state psychiatric hospital (approximately 5 hours away) and that Admin (Administrator/V1), DON (Director of Nursing/V2) and PCP (Primary Care Physician) were notified. R1's Progress Note dated [DATE] at 11:26 AM authored by V5 (Social Services Director/SSD) documented V5 spoke to V4 to see how R1 was doing and if she was coming back to the facility. V4 stated that R1 has nowhere else to go, so she will be coming back here until she can find R1 housing. V4 will call back if anything changes. R1's Progress Notes from [DATE] - [DATE] all document R1 being out of the facility at the psychiatric hospital. R1's Progresss Note dated [DATE] at 11:31 AM documented V5 called the psychiatric hospital to make sure they received the bedhold policy. CM (Case Manager) said that she will call back if they haven't received it. R1's Progress Notes nor her medical record show any evidence of R1 or V4 being provided with a written notice of transfer specifying the reason for transfer, the effective date of transfer, the location to which R1 was transferred, a statement of the resident's appeal rights, the name, address and telephone number of the Office of the State Long-Term Care Ombudsman nor the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act as required. R1's Progress Notes nor medical record show any evidence that written information was provided to R1 or V4 before transfer to the hospital which included information regarding the facility's bed hold policy. On [DATE] at 12:16PM, V4 (OSG Representative) stated she is the court ordered guardian for R1. V4 stated she received a voicemail the evening that R1 was sent out to the local emergency room on [DATE]. V4 stated she also received a call from the emergency room that R1 was being transferred to an outside behavioral/psychiatric hospital. V4 stated she had not received any other (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	calls from anyone regarding R1 until she received a call from the case manager at the psychiatric hospital on [DATE], informing her that R1 was ready for discharge but when the case manager called this facility, he was told they would not take R1 back and R1's bed hold was expired. V4 stated she called the facility on [DATE] and V1 (Administrator) and V3 (Business Office Manager/BOM) were not available so V4 had to leave a message for someone to call her back. V4 stated on [DATE], V1 called her back and stated that R1's bed hold was up and the facility had taken another admission so there were no beds available for R1, and she could be put on a waiting list. V4 stated she was not aware of the 10-day behold and she never received an explanation of anything. V4 stated she did not receive a call from the facility informing her that R1's time was getting close to losing her bed or anything. V4 stated she hadn't received a copy of the Bed Hold Policy until it was emailed to her by V5 on [DATE]. This was 11 days after R1's transfer so the bed hold was already expired and there was no way to appeal or to even have the opportunity to talk with the hospital to get R1 back to the facility before the 10 days were up. V4 stated R1 is still in the psychiatric hospital with no place to discharge to. V4 verified she received no written information from the facility until [DATE]. On [DATE] at 4:00PM, V2 (Director of Nursing/DON) stated she was at work the evening of [DATE] when R1 was taken to the hospital by police. V2 stated she was unsure if R1 was given the bed hold policy. V2 stated she believed it was sent with the other papers that were given to the police like her orders, POLST (Practitioner Orders for Life-Sustaining Treatment) form, and things like that. V2 said there were so many people trying to gather papers that she is not sure what all was sent with the police. V2 stated the reason the police were involved was because R1 was agitated and making threatening statements to others. V5 stated they could not get R1 calmed down so they called the police and the police took R1 to the hospital. On [DATE] at 4:20PM, V20 (Licensed Practical Nurse/LPN) stated she remembers the night R1 was taken out by the police, but she does not remember who prepared the paperwork that was sent with the police. V20 was asked when she sends someone out to the hospital, does she explain and give the bed hold policy to the resident or the resident representative and V20 stated no, she just puts the policy in the packet with everything else and gives it all to the people taking the resident out so they can give it all to the hospital. V20 stated that she doesn't ever remember receiving training on the bed hold policy. V20 was asked if she calls the POA or resident representative to notify them of transfer, does she at that time inform them of the bed hold policy and V20 stated no I don't tell them about the bed hold policy. On [DATE] at 9:15AM, V14 (Licensed Practical Nurse/LPN) was asked if she sends the Bed Hold Policy with residents and explain the policy when she sends residents out to the emergency room and V14 stated I just put it with all of the other papers and give it all to the ambulance crew. V14 was asked if she explains the bed hold to resident representatives when she calls to notify them of a resident transfer and V14 stated no I do not talk about the bed hold. On [DATE] at 2:00PM, V8 (Registered Nurse/RN) was asked what she sends with residents when they are transferred out to the hospital and V8 stated she sends face sheets, POLST forms, Physician Orders and the bed hold policy. V8 was asked if she explained the bed hold policy when providing it and V8 stated no, she just puts it in the yellow envelope with all the other papers. V8 was asked if she ever called the Power of Attorney or OSG representative to explain the bed hold policy when a resident goes out to the hospital and V8 stated usually not. An email from V5 (SSD) to V4 (OSG Representative) dated [DATE] at 11:52 AM with a subject line of BED HOLD POLICY documents Good morning, I'm sending the bed hold policy to you. Not sure it wasn't sent when (R1) went to the hospital. Was just making sure you receive a copy. The facility policy titled Bed Hold Policy Notification with review date of [DATE] documents This Bed Hold Policy will be given to you at the time of admission, and a copy will be given to you each time (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	you are transferred from the facility. Under normal circumstances, if you leave the facility for a hospitalization, you will be readmitted to the first available bed in a semi-private room. Under certain conditions, we can hold your existing bed for you at your request, so when you return to the facility, you will have the same bed and room as before. Neither Medicare nor Medicaid will pay to hold your same bed if you are hospitalized . If you are a private pay, Medicare or Medicaid resident, we will hold your same bed and room for you as long as you wish, at a charge to you of 100% of the normal daily rate. If your care is being paid for by the Veteran's Administration, we will hold your bed for the 48 hours unless prior approval for a longer period has been received form the VA that initiated your contract. The Nursing Home Care Act required a nursing facility to hold a bed for a maximum of 10 days when you are hospitalized . The facility must hold a bed (not necessarily your specific bed) for up to 10 days during a hospitalization. On the 11th day there is no requirement to hold a bed, but you are still a resident and will receive the next available bed when you are ready to return, even if there is a waiting list. There is no requirement under the Nursing Home Care Act to hold a bed for 10 days during a therapeutic home visit. However, you are still considered a resident and will be given the next available bed when you are ready to return, even if there is a waiting list. The facility Bed Hold Policy does not document who is responsible for providing written notifications to residents' responsible parties, Power of Attorneys, or Guardian representatives, nor does it include a time frame for when the written notices should be provided to them.		