

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 08/25/2025
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 0689 Level of Harm - Actual harm Residents Affected - Few	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 prevent a fall during transport and failed to implement interventions to prevent future falls for 3 (R11, R18, R49) of 6 residents reviewed for falls in a sample of 52. This failure caused R18 to fall backwards in her wheelchair while being transported in a facility van requiring R18 to be taken to the emergency room, given pain medication, suffering a skin tear, a knot to the head, bruising, and pain to the back and shoulders. Findings Include: 1.R18's admission record documents an admission date of 09/25/24 with diagnoses including: acute on chronic combined systolic and diastolic heart failure, acute and chronic respiratory failure, type 2 diabetes mellitus, chronic kidney disease, peripheral vascular disease, gastrointestinal hemorrhage, unspecified fracture of unspecified lumbar vertebra subsequent encounter for fracture with routine healing, seizures, presence of cardiac pacemaker, and chronic pain syndrome. R18's Minimum Data Set, dated [DATE] documents a brief interview of mental status of 10 indicating moderate impairment. Section GG indicates a manual wheelchair is utilized. On 08/20/25 at 10:45 AM, R18 stated, her back and neck still hurt and she can still feel the bump on her head that still hurts. R18 stated, she was in the facility van being transported to a doctor's appointment when she was not strapped in correctly, they only strapped the bottom of her wheelchair in, and when the driver pushed on the gas after turning around she went flying backwards in her wheelchair. R18 stated, she hit her head and her back and it hurt. She was checked out at the hospital and nothing was fractured but it really hurt and no one ever even asked her about it. R18's nurse's note dated 08/13/25 documents: This nurse was notified that while in route to resident's appointment in facility transport vehicle, resident fell backwards in wheelchair. This nurse told CNA (Certified Nursing Assistant) that notified staff to transport resident straight to emergency room (ER). Resident arrived back to facility at 12:50 PM with discharge papers. CT (computed tomography) of the head and spine completed along with x-ray to the left shoulder and left elbow that all were resulted normal. This nurse questioned resident on what happened once arrived back to facility and resident states we turned into a driveway to turn around and when we took off, I went flying backwards. I was buckled around my ankles. Baseline is alert and orientated and aware of situation and placement at facility x4. Neurological exam performed and within normal limits. Vital signs obtained: 97.5, 62 pulse, 16 respiration, 109/49. ROM x3 without pain. Resident complaining of pain to LUE (Left Upper Extremity). Tylenol given at 10:25 am at ER and will be given scheduled Oxycodone at 2pm. No shortening or deformity of extremities. Head to toe skin assessment completed. Resident has a new skin tear to top of left forearm measuring 0.3cm x 0.1cm with steri strips applied. Resident also has a knot to the back of the head. Not open. No other injuries visible at (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 146006	Facility ID: 146006 If continuation sheet Page 1 of 23

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F 0689 Level of Harm - Actual harm Residents Affected - Few	this time. Monitoring checks to be continued. Resident acting per baseline at this time. Resident is her own responsible party at this time. Doctor to be notified. R18's Daily skilled noted dated 08/17/25 at 11:26 PM documents: complaints of pain in upper back, knot remains to back of head. PRN (as needed) pain medications given, skin warm and dry, color fair, scattered bruising over upper arm remains from fall a few days ago. R18 continues to state that she hurts all over her back and shoulders, routine pain medication given and tolerated well. R18's nurse's note dated 08/18/25 at 1:09 PM documents: late entry: knot still present to back of head. R18's daily skilled note dated 08/18/25 at 10:42 PM documents: complaints of pain to back, resident received her scheduled oxycodone for pain management. R18's Nurse's note dated 08/20/25 at 3:19 PM documents: knot still present to back of head. R18's care plan documents a focus area of falls indicating R18 is at risk for falls relating to deconditioning, gait, and balance problems with an interventions including: staff educated on proper buckling of wheelchair in the facility van. On 08/22/25 at 10:24 AM, V21 (Licensed Practical Nurse) stated, she was the nurse working when the incident happened with R18. V21 stated V18 (CNA) had phoned her to state R18 had fallen backwards in the wheelchair during transport. R18 was sent to the ER for evaluation. V21 stated R18 did complain of pain to her head, back, and shoulders after she returned to the facility. V21 stated R18 has complained of pain since the fall and receives pain medication to assist with the pain. On 08/20/25 at 2:10 PM, V1 (Administrator) stated the facility document titled, Risk Management with incident #1954 with R18's name on it, is the fall investigation they have for R18's fall during transport. V1 stated, that document is the only and whole investigation they have. R18's risk management document dated 08/13/25 at 9:50 AM contains a section titled Nursing Description that documents: This nurse (V21) was notified by CNA (V18) that while en route to resident's (R18) appointment in facility transport vehicle, resident fell backwards in wheelchair. This nurse told CNA that notified staff to transport resident straight to (local ER). Resident (R18) arrived back to facility at 12:50 PM with discharge paper. CT of the head and spine completed along with x-ray to the left shoulder and left elbow that all were resulted normal. A section titled, resident description documents: this nurse questioned resident (R18) on what happened once arrived back to facility and resident states we turned into a driveway to turn and when we took off, I went flying backwards. I was buckled around my ankles. Baseline is alert and orientated and aware of situation and placement at facility x 4. The section titled, Description of Action Taken documents: neurological exam performed and within normal limits. Vital signs obtained: 97.5, 62 pulse, 16 respiration, 109/49. ROM (range of motion) x 3 without pain. Resident complaining of pain to LUE (left upper extremity). Tylenol given at 10:25 AM at ER and will be given scheduled Oxycodone at 2:00 PM. No shortening or deformity of extremities. Head to toe skin assessment completed. Resident has a new skin tear to top of left forearm measuring 0.3 cm (centimeters) x 0.1 cm with steri strips applied. Resident (R18) also has a knot to the back of the head. Not open. No other injuries visible at this time. Monitoring checks to be continued. Resident (R18) acting per baseline at this time. Resident (R18) is her own responsible party at this time. (Physician) to be notified. RCA (root cause analysis): improper tightness of straps. Immediate intervention: staff informed of proper buckling with wheelchair, this CNA (V18) was (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide supplements or provide supplements in an accessible manner for 2 (R8 and R16) of 6 residents reviewed for nutrition in a sample of 52. This failure further contributes to continued harm to R16, who has a documented history of severe weight loss. Findings include: 1. R16's admission record documents an admission date of 01/26/22 with diagnoses including: laceration without foreign body of right great toe without damage to nail, rhabdomyolysis, muscle weakness, flaccid neuropathic bladder, and anxiety disorder. R16's Minimum Data Set, dated [DATE] documents a brief interview of mental status of 04 indicating severely impaired. Section GG for eating documents setup or clean-up assistance. R16's order summary report documents a dietary order of: regular diet, mechanical soft texture, thin liquids consistency, health shake three times a day, nutritional ice cream two times a day and likes fruit with an order date of 07/22/24 with no end date listed. R16's care plan documents a focus concern of nutritional: R16 has a potential nutritional problem related to lack of natural teeth. R16 receives a regular, mechanically altered diet, and thin liquids. R16 eats meals in her room per her request. R16 has a good appetite. R16 has vanilla health shakes three times a day with meals, nutritional ice cream two times a day, a soft cookie between meals and she likes fruit dated 08/12/25. R16's interventions include: provide and serve supplements as ordered dated 02/03/22. R16's weight summary documents: 07/09/25 at 10:01 AM a weight of 137.0 pounds, -7.5% change, comparison weight - 04/17/25 - 190.0 pounds, -27.9% (weight loss), -53.0 pounds (loss). On 06/16/25 at 11:04 AM 141.0 pounds; -7.5% change, comparison weight on 03/25/25 at 191.3 pounds with -26.3% (weight loss) and -50.3 pounds (lost). On 05/18/2025 at 10:19 AM 147.5 pounds with -5.0% change, comparison weight 04/17/25 at 190.0 pounds and -22.4 % (weight loss) and -42.5 pounds. On 04/17/25 at 7:27 AM a weight of 190.0 pounds, on 03/25/25 at 7:10 AM a weight of 191.3 pounds, and 02/11/25 at 8:46 AM a weight of 189.5 pounds. R16's dietary note dated 07/09/25 at 3:49 PM documents: current body weight is 137 pounds, BMI (body mass index) 26.8 %, appropriate for age, usual body weight is approximately 190 pounds. R16 has lost approximately 50 pounds in 3 months, with the majority of weight loss taking place from April to May. Note weight loss coincides with buspirone ordered 04/09/25. R16's Dietary note dated 08/08/25 at 2:35 PM documents: awaiting monthly weight for August. R16 has been losing significant amounts of weight that coincide with buspar ordered on 04/09/25. R16 is noted to be refusing her buspar but her weight is not coming back up. R16's diet is regular diet, mechanical soft texture, thin liquids consistency, health shake three times a day, nutritional ice cream two times a day and R16 likes fruit. R16's intakes are varied, approximately 50% on average. R16 dislikes Med Pass, this was discontinued in July. Tried health shakes, which R16 reports she is liking, she prefers vanilla. R16 is still happy with her weight loss, states she is intentionally eating less. Encouraged good intakes for weight maintenance. Appropriate to continue with current nutrition intervention. On 08/18/25 at 12:48 PM, R16 had her lunch tray in front of her in her room. The plastic wrap was still covering the plate, the health shake was not opened, the nutritional ice cream was not opened, and the lids were still on the drinks. At 1:18 PM the tray was picked up, the health shake was still unopened, the nutritional ice cream was still unopened, the plastic wrap was off three quarters of the plate and a couple bites were eaten. On 08/19/25 at 12:43 PM, R16 had her lunch tray in front of her in her room. The plastic wrap was still covering the plate, the health shake was not opened, the nutritional ice cream was not opened, and the lids were still on the drinks. At 12:49 PM, R16 stabbed the food through the plastic wrap with her fork and pulled the plastic wrap most of the way off the plate. R16 then sat and stared at the food for approximately two minutes. After she was asked to try a bite (by the surveyor) she ate about three bites. The surveyor asked R16 if she could open the health shake, R16 did not answer but picked up the health shake and turned it over in her hand and set it back down. At 1:31 PM, R16 picked up the unopened popsicle that was on her tray, turned it over a (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	few times in her hands and put it back down. At 1:42 PM the tray was picked up, the health shake was still unopened, the nutritional ice cream was still unopened, and only about three bites of food were eaten. On 08/20/25 at 8:38 AM, R16's breakfast was sitting in front of her in her room. The health shake and the nutritional ice cream was unopened. The plastic wrap was still covering the plate and the lids were still on the drink. At 8:54 AM the tray was picked up with the health shake and nutritional ice cream still unopened. On 08/20/25 at 1:01 PM, R16 stated she had not had lunch yet. At 1:04 PM R16 received her lunch in her room with the health shake and nutritional ice cream unopened. The plate covered with plastic wrap and a plate cover and the drinks were still covered. At 1:33 PM her tray was picked up with no food eaten. Her health shake was left on her bedside table unopened. On 08/21/25 at 8:24 AM, R16 received her breakfast tray in her room, the health shake and nutritional ice cream were not opened. R16 stated, She don't feel good and she is not hungry. V16 (Helping Hands) went to pick the tray back up and then set it back down, leaving the health shake and nutritional ice cream unopened and the plate covered. R16 then picked up the orange juice and took a drink and stated ugh and made a grimacing face and set the orange juice back down. R16 was asked if she could open the health shake and R16 stated No. At approximately 8:55 AM R16's tray was picked up with the health shake and nutritional ice cream unopened. On 08/22/25 at 12:38 PM, V22 (Registered Dietician) stated, R16 has lost a lot of weight. V22 stated, she was relating the weight loss to the Buspar but she has refused the medication a while back but has not gained any of the weight back. V22 stated it is hard to get any information out of R16, you usually have to ask leading questions to get a yes or no answer. V22 stated every time she has seen R16 she has been sitting in her chair hunched over with her hands on her stomach. V22 stated, she has never been with R16 during a meal time but she would expect the health shakes and nutritional ice creams to be given to her in a form she can access them. V22 stated, she would expect all supplements and recommended items to be given to the residents and given in a form they can eat or drink them. On 08/21/25 at 3:35 PM, V1 (Administrator) stated, she does not think R16 could always open the health shakes or nutritional ice cream. She stated she would expect set up and clean up assistance to mean; uncovering items on the tray, opening items, buttering bread if needed, tasks similar to that. V1 stated, she did believe that R16 could use some encouragement lately. On 08/21/25 at 3:12 PM, V3 (Registered Nurse) stated, she does not believe R16 could open the health shake carton by herself. This week R16 has seemed like she has not been doing as well so she believes R16 would struggle with opening both the health shake and the nutritional ice cream. On 08/21/25 at 3:18 PM, V14 (Licensed Practical Nurse) stated, R16 has declined, she does not believe that she could open the health shake by herself and she might struggle with the nutritional ice cream. V14 stated, she believes especially lately having her tray set up for her and some encouragement could be helpful. 2.R8's admission record documents an admission date of 03/07/22 with diagnoses in part of unspecified sequelae of cerebral infraction, vascular dementia, cognitive communication deficit, muscle weakness, other lack of coordination, and dysphagia. R8's MDS dated [DATE] documents no BIMS should be conducted due to resident is rarely/never understood. Section GG documents eating as dependent. Section K documents under weight loss as yes not on prescribed weight-loss program. R8's Care Plan with a revision date of 07/23/25 documents a focus area of: Nutritional: R8 has nutritional problem or potential nutritional problem r/t (related to) dementia. R8 requires assistance with feeding and eating. R8 has her own teeth with likely cavities. Will consult with dentistry as needed. R8's appetite is fair. Assistive devices: Divided plate. Intervention for this focus area include: 10/28/22 SC (Super Cereal) at BF (Breakfast), 4oz (Ounces) of 2.0 BID (Two times a day) with med pass, magic cup at lunch, whole milk TID (Three time a day) with meals, HS (Nighttime) snack, resident to use sectional plate, dessert x 2 at lunch and dinner. R8's Physician orders dated 07/22/24 documents an order summary for Regular diet pureed texture, thin liquids consistency, for HELP at all meals with feeding. SC at breakfast, magic cup at lunch, resident to use sectional plate with all meals. Whole milk, protein powder at breakfast and lunch. Nosey cup with drinks. No End Date. On (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide a pest free environment. This failure has the potential to affect all 66 residents residing at the facility. 1.On 08/18/25 at 12:16PM observed R68 in the dining room she was waving her hands in the air she was trying to wave the flies away from her hair and face. R68 stated she is so tired of these flies being all over her and on her food. R68's MDS (Minimum Data Set) dated 07/17/25 documents in Section C a BIMS (Brief Interview for Mental Status) score of 08 which indicates R68 has moderately impaired cognition. On 08/18/25 at 12:18PM observed R14 sitting at the table in the dining room she had pork, au gratin potatoes, zucchini with tomatoes and frosted cake. R14 was trying to take a bite of her frosted cake and she was waving over her cake trying to get the flies off of her cake. Observed 2 flies on top of the frosting on the cake. On 08/18/25 at 12:32PM. R14 stated that she is so tired of all the flies in the dining room. R14 stated that the facility needs to do something about it. 2.R14's admission record dated 08/21/25 documents an admission date 05/24/23 with diagnoses in part of Chronic Obstructive pulmonary disease, type 2 diabetes mellitus, and major depressive disorder. R14's MDS dated [DATE] documents in Section C a BIMS score of 14 which indicates R14 is cognitively intact. 3.On 08/18/25 at 12:22PM observed R58 being served ground pork, au gratin potatoes, bread, frosted cake, zucchini with tomatoes, Nutritional Supplement. Observed flies on top of R58's au gratin potatoes and frosted cake. Observed R58 waving over food trying to get flies off of her food. 4.On 08/18/25 at 12:23PM, R58 asked V10 (Registered Nurse) why the facility does not have fly traps or strips. Observed V10 waving flies off of R58's tray. 5.On 08/18/25 at 12:32PM, R58 stated that she is so sick of all the flies in the dining room when she is eating. R58 stated that the flies are so bad right now and they are all over the building. R58's MDS dated [DATE] documents in Section C a BIMS score of 8 which indicates R58 has moderately impaired cognition. 6.On 8/18/25 at 1:07pm during the lunch meal R28 was noted to be falling asleep during that time several flies were noted landing on his food. Staff woke him and he continued to eat the food. He attempted to wave the flies away but has right sided paralysis and was having difficulty trying to eat and effectively wave the flies away. R28's care plan documents R28 has a decrease of functional mobility on right side of body. 7.08/19/2025 12:04 PM observed oxygen concentrator in dining room, not in use, and the top of it covered in multiply brown spots with flies landing on it. Window ledge behind the oxygen concentrator has multiply brown spots with dead and alive flies. 08/20/2025 12:13 PM Oxygen concentrator in dining room still, not in use, the top of it is covered in multiply brown spots with flies landing on it. Window ledge has alive and dead flies and brown spots (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on it. On 8/21/2025 at 9:24 AM, V1 (Administrator) stated the brown spots on top of the concentrator and window ledge look to be fly feces and stated there are dead flies in the window ledge and she will get it cleaned up asap. 8. On 08/19/25 at 12:13 PM there were six flies observed flying around and landing on R38's food and table. On 08/20/25 at 9:02 AM there were three flies landing on R44's food and bedside table. On 08/20/25 at 9:18 AM there were four flies observed on the C hallway. On 08/19/25 at 1:19 PM there were three flies landing on R16's food and bedside table. On 08/20/25 at 9:55 AM there were four flies observed on the A hall. On 08/21/25 at 7:23AM, V1 (Administrator) stated that flies are a bad problem at the facility right now. V1 said that they put stool bags outside of the building trying to lure flies away from the door along with they have the curtain fan at the door to try and help. V1 said that they think a lot of the flies are coming in are from the residents going in and out all the time. V1 said that they try to organize residents going in and out but it's their right to go in and out as they please. V1 said that they are going to see what they can do to reduce the flies. On 08/21/25 at 7:42AM, V2 (Director of Nursing/DON) stated that the facility does have a problem with flies right now but it's that time of the year. On 08/21/25 at 11:03AM, V11 (Certified Nurse Assistant) stated that the facility does have a problem with flies all over the building right now. On 08/20/25 at 10:10 AM during resident council, residents stated there were a lot of flies in the facility. They are always waving them off of them or their food. The facility document dated 08/18/25 titled, Midnight Census Report documents 66 residents residing at the facility. The facility policy titled Pest Control' documents a policy statement of our facility shall maintain an effective pest control program. Under Policy Interpretation and Implementation #1 This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure call lights were within reach for 4 of 4 (R11, R38, R41, and R49) residents reviewed for call lights on the sample list of 52. Findings include: 1. R11's admission Record documents an admission date of 11/6/24 with diagnoses including in part: end stage renal disease, dependence on renal dialysis, and diabetes. R11's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 08, indicating moderate cognitive impairment. R11's recent Care Plan document R11 is a fall risk with an intervention documented as be sure R11's call light is within reach and encourage R11 to use it for assistance as needed. R11 needs prompt response to all requests for assistance. R11's Fall Risk Assessment dated 8/16/25 documents R11 is a high risk for potential falls. On 8/18/25 at 10:12 AM, R11 was lying in her bed sideways with legs hanging off bed and her head against the wall with her pants pulled down to her knees. R11's Call light was laying in the floor by the nightstand, out of reach for R11. On 8/21/25 at 11:54 AM, V3 (Assistant Director of Nursing) stated R11 can use her call light, V3 stated she has answered her call light before. V3 stated the call light should be in reach. 2. R38's admission Record documents an admission date of 12/19/23 with diagnoses including in part: chronic obstructive pulmonary disease with (acute) exacerbation, essential hypertension, hyperlipidemia, overactive bladder, dementia, gastro-esophageal reflux disease, and iron deficiency anemia. R38's MDS dated [DATE] documents a BIMS of 02, indicating severe cognition impairment. R38's recent Care Plan documents R38 is a fall risk with an intervention of be sure R38's call light is within reach and encourage him to use it for assistance as needed. R38 needs prompt response to all requests for assistance. On 8/18/25 at 10:09 AM, R38 was laying in his bed, and the call light was sitting in his roommates recliner across the room, out of reach. On 8/21/25 at 11:54 AM, V3 stated R38 is able to use his call light, and it should be in reach. 3. R41's admission Record documents an admission date of 5/21/24 with diagnoses including in part: muscle weakness, dysphagia, difficulty in walking, and need for assistance with personal care. R41's MDS dated [DATE] documents a BIMS of 04, indicating severe cognitive impairment. R41's recent Care Plan documents R41 is at risk for impaired cognitive function/impaired thought process related to confusion. R41 is alert and oriented but has confusion at times. R41 is able to make his needs and wants known to staff without difficulty. R41 communicates with staff verbally and understands staff without difficulty. The same Care Plan also documents R41 is at risk for falls with an intervention documenting be sure R41's call light is within reach and encourage the resident to use it for assistance as needed. R41 needs prompt response to all requests for assistance. On 8/18/2025 at 9:47 AM, R41 was laying in his bed, and the call light was at the foot of his bed out of reach, under the covers. 08/19/2025 at 10:32 AM, R41 was in bed and call light was at the foot of the bed, under the covers and was out of reach. On 8/21/2025 at 11:54 AM, V3 stated R41 is able to use his call light, V3 stated he has good days and bad days, but his call light should be in reach. 4. R49's admission Record documents an admission date of 7/31/25 with diagnoses including in part: diabetes, anxiety disorder, pain, orthostatic hypotension, syncope, and collapse. R49's MDS 8/12/25 documents a BIMS of 07, indicating R49's cognition is severely impaired. On 8/18/25 at 1:14 PM, observed R49 lying in bed with his pants on the floor. R49 was asking for help from surveyor, he said he can't get out of bed. The call light was at the end of his bed, not in reach. On 8/21/2025 at 11:54 AM, V3 stated R49 can use his call light, V3 stated she has answered his call light before. V3 stated his call light should be within reach. On 8/21/25 at 7:23AM, V1 (Administrator) stated call lights should be within reach for all residents, at all times. On 8/21/25 at 1:50 PM, V1 stated they do not have a call light policy. A facility policy titled Fall Management dated 2019 documents under Standard Fall/Safety Precautions: All Residents 1. At the time of admission and in accordance with the plan of care the resident will be oriented to use the nurse call device. The nurse call device will be placed within the resident's reach at all times. The location of the placement will be verbalized for those residents with visual deficits.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to dispose of medications properly and failed to check expiration dates for 5 of 5 (R3, R7, R31, R45, and R61) residents reviewed for medication expiration and storage in the sample of 52. Findings include: 1. R7's admission record documents an admission date of [DATE] and a discharge date of [DATE] with diagnoses including in part: diabetes, emphysema, chronic obstructive pulmonary disease, and acute respiratory failure with hypoxia. On [DATE] there was an expired inhaler for R7 in the medication cart, Ventolin HFA 108 mcg/act (micrograms per actuation aerosol inhaler) 2 puffs inhaled orally every 4 hours as needed for shortness of breath, with an expiration date of 07/2025 with 177 doses left. On [DATE] at 10:11 AM, V21 (License Practical Nurse) confirmed the medication was expired and stated R7 was using that medication prior to his discharge on [DATE]. 2. On [DATE] at 8:48am, a review of the facility medication storage was done. There was a plastic container in the bottom cabinet with multiple medications in it. A Reconstituted Bag of normal saline and ampicillin dated [DATE] that was prescribed to R61. 2. An unopened Medrol (steroid) dose pack dated [DATE], prescribed to R31. 3. An unlabeled and undated Trelegy inhaler with 14 doses left. 4. A partially used tube of Mupirocin (topical antibiotic ointment), that was undated, with no expiration date. One of the top cabinets contained various medical supplies and patient specific medications behind the medical supplies. 1. A partially administered card of Bactrim DS dated [DATE], that was prescribed to R45. 2. A partially administered card of Flagyl (antibiotic) dated [DATE], that was prescribed to R3. 3. A partially administered card of Tetracycline (antibiotic) dated [DATE], that was prescribed to R3. R61's admission Record documents an admission date of [DATE] and a discharge date of [DATE], with the following diagnoses in part, End stage renal disease and anemia. R61's Physician's Order Sheet dated [DATE] documents no active orders for Intravenous Ampicillin. R31's admission Record documents an admission date of [DATE] with the following diagnoses in part, chronic obstructive pulmonary disease with (Acute) exacerbation, Atherosclerotic heart disease of native coronary artery without angina pectoris. R31's Physician's Order Sheet dated [DATE] documents no active orders for a Medrol dose pack. R45's admission Record documents an admission date of [DATE] with the following diagnoses in part, Polyarthritis and pressure ulcer of the sacral region, unspecified stage. R45's Physician's Order Sheet dated [DATE] documents no active orders for Bactrim DS. R3's admission Record documents an admission date of [DATE] with the following diagnoses in part, malignant neoplasm of colon, unspecified and helicobacter pylori as the cause of disease classified elsewhere. (continued on next page)		

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

Printed: 07/18/2026
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 08/25/2025
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Physician's Order Sheet dated [DATE] documents no active orders for Flagyl or Tetracycline. On [DATE] at 9:13am, V2 (Director of Nursing/DON) stated he had just started; however his expectation would be that those medications should be sent back. On [DATE] at 9:16am, V3 (Assistant Director of Nursing/ADON) stated these medications should have been sent back. 3. On [DATE] at 10:11 AM, there was one bottle of Vitamin E 90 mcg that expired on 01/2025, in the medication cart on hallway A. On [DATE] at 10:11 AM, there was one expired bottle of multi-Vitamin with Iron with an expiration date of 05/2025, in the medication cart on hallway A. On [DATE] at 10:56 AM, there was one expired bottle of B-Complex with vitamin C that expired on 03/2025. On [DATE] at 10:56 AM, there was one expired bottle of Preservision that expired on 02/2025. On [DATE] at 10:56 AM, V3 (Assistant Director of Nurses) stated expired medication should not be left on the medication carts. A facility policy titled Medication Administration dated [DATE] documents under Procedure: 7. If the medication is discontinued or outdated, remove medication from proper disposal. Ointments, drops and inhalers to be kept separate from other medications. Outdated drugs. will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedure. A facility policy titled Medication Storage dated [DATE] documents under Procedure: 14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures and reordered from the pharmacy if a current order exists.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to perform hand hygiene while performing eating and drinking assistance for 4 (R52, R57, R8 and R68) of 6 residents reviewed for dining in a sample of 52. Findings include: 1. R52's admission Record documents an admission date of 6/10/2020 with the following diagnoses in part, Alzheimer's disease with early onset, Major Depressive Disorder and Gastro-Esophageal Reflux Disease without esophagitis. R52's Minimum Data Set (MDS) dated [DATE] documents that a Brief Interview for Mental Status (BIMS) was not completed because resident is rarely/never understood. Section GG- Functional Abilities documents that R52 is dependent on staff for eating. R52's current Care Plan document's that R52 requires extensive assistance with Activities of Daily Living. 2. R57's admission Record documents an admission date of 2/23/23 with the following diagnoses in part, Gastro-Esophageal Reflux Disease without esophagitis, unspecified hearing loss, unspecified ear, and several intellectual disabilities. R57's MDS dated [DATE] documents a BIMS was not completed because resident is rarely understood. Section GG- Functional Abilities documents R57 is dependent on staff for eating. R57's Care Plan documents that R57 requires staff assistance during mealtime. On 8/18/25 at 1:05pm, 8/19/25 at 12:23 PM, and 8/20/25 at 12:46 PM, V4 (CNA) was observed providing feeding assistance to R52 and R57. V4 was not observed using hand hygiene in between assisting residents during the mealtime observations. On 8/20/25 at 2:26pm, V4 (CNA) stated she should have performed hand hygiene in between assisting residents with meals. 3. R8's admission record documents an admission date of 03/07/22 with diagnoses in part of unspecified sequelae of cerebral infraction, vascular dementia, cognitive communication deficit, muscle weakness, other lack of coordination, and dysphagia. R8's MDS dated [DATE] documents no BIMS should be conducted due to resident is rarely/never understood. Section GG documents eating assistance as dependent. R8's Care Plan with a revision date of 07/23/25 documents that R8 is to receive assistance at mealtimes. 4. R68's admission Record documents an admission date 3/27/24 with diagnoses including Multiple Sclerosis, moderate protein-calorie malnutrition, cognitive communication deficit, and muscle weakness. R68's MDS dated [DATE] documents a BIMS score of 8, indicating moderate cognitive impairment. Section GG documents that R68 is dependent, requiring assistance with eating. R68's Care Plan (revision date 6/21/24) documents that R68 requires assistance with intake. On 08/18/25 at 12:46PM, R68 was observed being assisted by V2 (Director of Nursing/DON) who would give R68 a couple of bites with his right hand and then he would turn and give another few bites to R8. V2 then was noted to be rubbing his right eye with his right hand and then he grabbed R68's bread with his bare hands and attempted to give R68 a bite of the bread, but R68 refused. V2 then went and grabbed R8's cup which had the straw in it, and he grabbed the straw with his right hand to try to give R8 a drink. V2 never completed hand hygiene before assisting either of the resident or in between assisting each resident. On 08/21/25 at 7:23AM, V1 (Administrator) stated that all staff should wash their hands before assisting a resident with eating. V1 also stated that staff should complete hand hygiene if touching face or anything. V1 also stated that all staff should perform hand hygiene in between each resident they are assisting. On 08/21/25 at 7:42AM, V2 (DON) stated that he supposes that hand hygiene should be done before and in between each resident. V2 stated that he didn't remember rubbing his eye when he was assisting R68 and R8 with their meal. V2 said that he did grab R68 bread with his bare hand and was trying to give R68 a bite of the bread, but that R68 refused it. The facility policy titled Handwashing/Hand Hygiene with a review date of 2020 documents the policy statement: This facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation documents under #7b. Before and after direct contact with residents .o. Before and after eating or handling food, p. Before and after assisting a resident with meals.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and record review the facility failed to provide Influenza and Pneumococcal Immunizations for 4 of 5 residents (R17, R51, R59 and R66) reviewed for Influenza and Pneumococcal Immunizations in the sample of 52. Findings include: Findings include: 1. R17's Transfer/Discharge Report documents a date of birth that indicates R17 is [AGE] years old. This report also documents an admission date of 7/25/25, with the following diagnoses listed in part; acute respiratory failure with hypercapnia and chronic obstructive pulmonary disease, unspecified. R17's current complete medical record has no vaccinations listed in the immunization record or refusals of immunizations documented. 2. R51's Transfer/Discharge Report documents a date of birth that indicates R51 is [AGE] years old. This report also documents an admission date of 8/6/25, with the following diagnoses listed in part, bullous pemphigoid and essential primary hypertension. R51's complete medical record has no vaccinations listed in the immunization record or refusals of immunizations documented. 3. R59's Transfer/Discharge Report documents a date of birth that indicates R59 is 81. This report also documents an admission date of 1/24/25 and the following diagnoses in part, chronic obstructive pulmonary disease with (acute) exacerbation, acute respiratory failure with hypercapnia, and acute respiratory failure with hypoxia. R59's current complete medical record has no vaccinations listed in the immunization record and no refusals of immunizations documented. 4. R66's Transfer/Discharge Report documents a date of birth that indicates R66 is [AGE] years old. This report also documents an admission date of 1/31/25, with the following diagnoses listed in part; chronic cough, gastro-esophageal reflux disease without esophagitis, and nonrheumatic aortic (valve) insufficiency. R66's current complete medical record documents an influenza vaccination given on 9/1/23, there are no other vaccinations and no refusals of immunizations documented. On 08/20/25 at 2:26 PM, V1 (Administrator) stated she has been here since November and they have not offered or administered any influenza, pneumococcal, or covid-19 vaccinations. V1 stated all immunizations are listed on the immunization record in the electronic health record. The facility policy titled Influenza, Prevention and Control Seasonal with a revision date of 2020, documents Unless contraindicated, all residents and staff will be offered the vaccine. The facility policy titled Pneumococcal Vaccine with a revision date of 2023 documents, All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. According to the Centers for Disease Control website, https://www.cdc.gov/flu/highrisk/65over.html, the following recommendations were retrieved in part as of 8/21/25: People 65 years and older are at higher risk of developing serious flu complications compared with young, healthy adults. This increased risk is due in part to changes in immune defenses with increasing age. While flu seasons vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease. Ideally, everyone should be vaccinated by the end of October. According to the Centers for Disease Control website, https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, the following recommendations were retrieved in part as of 8/21/25: Administer PCV15, PCV20, or PCV21 for all adults 50 years or older who have never received any pneumococcal conjugate vaccine or those whose previous vaccination history is unknown. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement Covid-19 immunization policies and offer and/or provide Covid-19 immunizations for 4 residents of 5 residents (R17, R51, R59, and R66) reviewed for immunizations in a sample of 52. Findings include: 1. R17's Transfer/Discharge Report documents a date of birth that indicates R17 is [AGE] years old. This report also documents an admission date of 7/25/25, with the following diagnoses listed in part; acute respiratory failure with hypercapnia and chronic obstructive pulmonary disease, unspecified. R17's current complete medical record has no vaccinations listed in the immunization record or refusals of immunizations documented. 2. R51's Transfer/Discharge Report documents a date of birth that indicates R51 is [AGE] years old. This report also documents an admission date of 8/6/25, with the following diagnoses listed in part, bullous pemphigoid and essential primary hypertension. R51's complete medical record has no vaccinations listed in the immunization record or refusals of immunizations documented. 3. R59's Transfer/Discharge Report documents a date of birth that indicates R59 is 81. This report also documents an admission date of 1/24/25 and the following diagnoses in part, chronic obstructive pulmonary disease with (acute) exacerbation, acute respiratory failure with hypercapnia, and acute respiratory failure with hypoxia. R59's current complete medical record has no vaccinations listed in the immunization record and no refusals of immunizations documented. 4. R66's Transfer/Discharge Report documents a date of birth that indicates R66 is [AGE] years old. This report also documents an admission date of 1/31/25, with the following diagnoses listed in part; chronic cough, gastro-esophageal reflux disease without esophagitis, and nonrheumatic aortic (valve) insufficiency. R66's current complete medical record documents an influenza vaccination given on 9/1/23, there are no other vaccinations or refusals of immunizations documented in this record. On 08/20/25 at 2:26 PM, V1 (Administrator) stated she has been here since November and they have not offered or administered any influenza, pneumococcal, or covid-19 vaccinations. V1 stated all immunizations are listed on the immunization record in PCC. V1 stated there was no policy regarding covid-19 vaccinations. According to the Centers for Disease Control (CDC) website, https://www.cdc.gov/covid/vaccines/long-term-care-residents.html, the following recommendations were retrieved as of 8/21/25: CDC recommends everyone ages 65 years and older, including people who live and work in LTC settings, get 2 doses of an updated COVID-19 vaccine 6 months apart.		

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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 ensure residents were treated with dignity for 3 of 4 residents (R21, R35, R48) reviewed for dignity in the sample of 52. Findings include: 1.R21's admission Record documents an admission date of 7/16/25 with the following diagnoses in part, Parkinsonism, major depressive disorder, anxiety, and repeated falls. R21's only completed Minimum Data Set, dated [DATE] does not document a Brief Interview for Mental Status. R21's current care plan only documents one focus area, Nutritional. On 8/20/25 at 12:31pm, R21 was observed in the dining room with a puddle under her and her jeans appeared wet. On 8/20/25 at 12:40pm, R21 was observed still sitting in the dining room with a puddle under her and wet pants. On 8/20/25 at 12:44pm, R21 was observed wheeling back to her room with her pants still wet. On 8/20/25 at 2:23pm, R21 was observed laying in her bed, still in wet pants. On 8/20/25 at 2:26pm, V4 (CNA/ Certified Nursing Assistant) stated she was not aware that R21 had wet pants on, but would follow up on the situation right away. V4 stated she was not quite sure how much assistance with toileting R21 required, but she thought she was independent. V4 stated R21 is fairly new. 2.R48's admission record documents an admission date of 09/13/24 with diagnoses including: cerebral infarction, dysphagia following cerebral infarction, dysarthria following cerebral infarction, anxiety disorder, quadriplegia, and schizophrenia. R48's minimum data sheet dated 07/24/25 documents a brief interview of mental status of 14 indicating cognitively intact. Section GG documents R48 is dependent for toileting and partial to moderate assistance for toilet transfers. The section titled, Bowel Continence documents R48 is always incontinent. On 08/20/25 at 7:50 AM, R48 was in the dining room eating breakfast. At 8:28 AM, R48 was in the dining room wet in his groin area from hip to hip to just past the top of his leg. At 8:43 AM, R48 was in his wheelchair near the exit of the dining room. At 8:48 AM, V19 (Certified Nursing Assistant) took R48 to his room. At 8:52 AM, R48 was laying in his bed and was still wet. At 9:00 AM, R48 was still in his bed wet. At 9:06 AM, R48 was still laying in his bed wet. At 9:21 AM, R48 was laying in his bed sleeping still wearing the same wet gray sweatpants. On 08/22/25 at 10:29 AM, V1 (Administrator) stated, if a resident was visibly wet in the dining room, she would not expect that staff interrupt their meal, unless the resident asked to be changed, but she would expect the resident to be taken and cleaned up right after they were done eating. She would not (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	want them to be put to bed without them being cleaned up and changed. 3.R35's admission Record documents an admission date of 7/25/22 with diagnoses including in part epilepsy and lack of expected normal physiological development in childhood. R35's MDS dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 12, indicating moderately impaired cognition. The same MDS documents R35 is setup and clean-up assistance for personal hygiene. R35's most recent Care Plan documents R35 has an Activities of Daily Living (ADL) Self Care Performance Deficit. R35 requires assistance with other ADL's. On 8/18/25 at 1:03 PM, R35 had long hair on her chin about 1 inch in length and about 0.5 inches on her upper lip. R35 stated the facial hair does bother her and they only shave it when they shower her. R35 stated she thinks she only gets about one shower a week. On 8/19/2025 at 11:00 AM, R35's facial hair was still present to chin and upper lip. Resident Grievance/Concern Follow-Up Form dated 8/14/25 at 10:00 AM documents under Describe the nature of the grievance/concern: Shaving, and under Recommendations: education to all staff regarding all of the above. On 8/20/25 at 2:24 PM, V5 (Certified Nursing Assistant/CNA) stated she shaves residents on shower days and if she sees facial hair in between showers, she will shave the resident. On 8/20/25 at 2:26 PM, V6 (CNA) stated she shaves residents when she gives them their shower but if needed, she will shave them between showers. On 8/20/25 at 2:28 PM, V7 (CNA) stated she shaves residents during their shower and if they needed shaved between showers she will do it. On 8/20/25 at 2:30 PM, V4 (CNA) stated she shaves residents during showers and whenever needed. V4 stated shaving is part of their ADL's and should be done daily if needed. On 8/20/25 at 2:32 PM, V3 (Assistant Director of Nursing) stated staff should be shaving residents during their shower and in between as needed. On 8/25/25 at 11:48 AM, V1 (Administrator) stated they do not have a policy related to grooming or shaving.		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an initial comprehensive assessment for 1 of 3 residents (R21) reviewed for assessments in a sample of 52. Findings Include: R21's Transfer/Discharge Report documents an admission date of 7/16/25 with the following diagnoses in part, Parkinsonism, major depressive disorder, anxiety, and repeated falls. R21's medical record only contains the entry Minimum Data Set (MDS) dated [DATE], it does not document a Brief Interview for Mental Status. There was no admission assessment for R21 in R21's medical record. On 8/21/25 at 12:00pm, V1 (Administrator) stated under the assessment tab, there is a baseline assessment that should be completed by nursing on admission, and they believe that staff are mistaking this for other things. V1 stated staff have been educated. V1 stated they do not have a policy for MDS assessments. On 08/21/2025 at 2:45 PM, V8 stated that R21's entry MDS had been completed, but not her admission. V8 stated the reason R21's admission MDS was not completed was because she must have missed it. V8 stated she has a calendar that she keeps with the due dates of everyone's assessments, and she did not have R21's on there. V8 stated she would get right on it. V8 stated R21's admission assessment should have been completed 14 days after admission.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive care plan and failed to develop a plan of care for indwelling urinary catheter use for 2 of 4 residents (R11, R21) reviewed in a sample of 52. Findings include: 1. R21's Transfer/Discharge Report documents an admission date of 7/16/25 with the following diagnoses in part; Parkinsonism, major depressive disorder, anxiety and repeated falls.R21's only completed Minimum Data (MDS) Set dated 7/16/25 does not document a Brief Interview for Mental Status.R21's current care plan only documents one focus area, Nutritional.On 8/21/25 at 12:00pm, V1 (Administrator) stated the care plan for R21 that only contains one focus area is the current care plan. V1 stated under the assessment tab, there is a baseline assessment that should be completed by nursing on admission, and they believe that they are mistaking this for other things. V1 stated staff have been educated.2. R11's Transfer/Discharge Report documents an admission date of 11/6/24 with the following diagnoses in part; end stage renal disease, dependent on renal dialysis and chronic kidney disease.R11's Minimum Data Set, dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 08, indicating moderate cognitive impairment.R11's Resident Summary Report dated 8/21/2025 documents urinary catheter care every shift with an order date of 8/9/2025 and R11 is to follow up with urology due to indwelling catheter present due to acute kidney injury with cystitis.8/18/2025 at 10:12 AM, R11 was observed to have a urinary catheter in place. R11's current care plan does not have a focus area for a urinary catheter. On 8/21/2025 at 10:11 AM, V1 (Administrator) stated she didn't know R11 had a urinary catheter and doesn't know why it isn't in her care plan. On 8/21/2025 at 10:17 AM V8 (MDS Coordinator) stated R11 wasn't care planned for having a Urinary Catheter because she just found out she had one. Facility policy titled Care Planning - Interdisciplinary Team with a revision date of September 2013 , states the following; Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 assistance with meal supplements, toenail care and incontinence care for 3 of 3 (R38, R48 and R50) residents reviewed for help with Activities of Daily Living (ADL's) in a sample of 52. Findings include: 1.R38's admission record documents an admission date of 12/19/23 with diagnoses including: chronic obstructive pulmonary disease with (acute) exacerbation, essential hypertension, hyperlipidemia, overactive bladder, dementia, gastro-esophageal reflux disease, and iron deficiency anemia. R38's Minimum Data Set, dated [DATE] documents a brief interview of mental status of 02 indicating severe cognition impairment. Section GG documents R38's eating ability as supervision or touching assistance needed. R38's order summary report documents a diet order of regular diet, mechanical soft texture, thin liquids consistency, and health shakes two times a day with an order date of 07/22/24 with no end date listed. R38's care plan documents a focus area of nutrition; R38 is at risk for complications with weight and nutrition relating to weight loss. R38 has a regular, mechanical soft thin liquids, health shakes two times a day with meals, med pass 90 milliliters two times a day, encourage juice with meals and may mix supplements for acceptance dated 08/12/25 with interventions including: increase health shakes to three times a day with meals dated 07/24/24 and registered dietician to assess and recommend as needed dated 04/23/24. On 08/18/25 at 12:22 PM, R38's lunch was served to R38 in the dining room with the health shake unopened. R38 drank his water and his milk but made no effort to drink his health shake and no one encouraged him. On 08/19/25 at 12:08 PM, R38 received his lunch including his unopened health shake. At 12:25 PM, R38 watched his table mate pick up his health shake and shake it, so R38 picked up his health shake and shook his. His tablemate looked at how to open his and attempted to open it, then R38 look at his health shake and attempted to open his, R38 struggled for 3 minutes trying to get it open and was unable to get it open. At approximately 12:29 PM V18 (Certified Nursing Assistant/CNA) noticed R38 was struggling with the health shake and opened it for him. On 08/20/25 at 7:43 AM, R38 received his breakfast with an unopened health shake. At 8:13 AM, R38 left the dining room with the unopened health shake sitting in front of him. R38 did not receive any assistance or encouragement during this meal. On 08/20/25 at 12:11 PM, R38 had his lunch in front of him with the health shake unopened. R38 was staring at his food and not eating it. At 12:28 PM, V18 (CNA) opened his health shake for him and he started eating his lunch and drinking his health shake. On 08/21/25 at 7:36 AM, R38 had his breakfast in front of him with an unopened health shake. On 08/21/25 at 7:48 AM, R38 was eating his breakfast but had made no effort for his health shake. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/25 at 7:48 AM (when asked if he could open his health shake) R38 stated, sometimes he can't open them, he doesn't know why. On 08/21/25 at 7:48 AM, V11 (CNA) was asked to open R38's health shake, after the health shake was opened, R38 drank his health shake while finishing the last of his breakfast. On 08/21/25 at 3:12 PM, V3 (Registered Nurse) stated, she does not believe R38 could open the health shake carton by himself. On 08/21/25 at 3:18 PM, V14 (Licensed Practical Nurse) stated, she does not believe that R38 could open the health shake by himself, the health shakes are kind of hard to open. V14 stated, she believed he would struggle with opening the health shake and the shakes should be opened for him when they set up his food. On 08/21/25 at 3:35 PM, V1 (Administrator) stated, she believes R38 would struggle with opening the health shakes and would probably not be able to open the health shakes. V1 stated, the health shakes should be opened by staff when they set up R38's food. On 08/22/25 at 12:38 PM, V22 (Registered Dietician) stated, she would expect all supplements and recommended items to be given to the residents and given in a form they can eat or drink them. 2.R50's admission Record documents an admission date of 11/8/24 and a discharge date of 8/18/25 with diagnoses including in part: spinal stenosis, compression of brain, osteoarthritis of knee, unsteadiness on feet, fusion of spine cervicothoracic region, and diabetes. R50's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 15, indicating R50's cognition is intact. The same MDS documents R50 is setup or clean-up assistance for personal hygiene. On 8/18/25 at 10:36 AM, R50 stated he has been asking for the last 10 months, since he's been here to get his toenails cut. R50 stated they tell him they don't have clippers. R50 stated his shoes make his toenails hurt because they are so long. Observed R50's toenails and they were about 2 inches past the end of this toes and growing sideways. On 8/20/25 at 2:30 PM, V4 (Certified Nursing Assistant) stated she has seen R50's toenails previously and they were pretty long and needed cut. V4 stated she put it on his shower sheet that they needed cut. V4 stated she doesn't know who takes care of toenails, but she gave the shower sheet to the nurse working that day. On 8/20/25 at 2:32 PM, V3 (Assistant Director of Nurses) stated she hasn't seen R50's toenails. V3 stated any nurse can cut toenails but a lot of them won't because they are worried or don't have time, so she tends to cut toenails more. V3 stated any nurse can trim toenails. V3 stated R50's toenails should have been taken care of. On 8/21/25 at 2:30 PM, V3 stated she remembered after we talked the day prior that she did know R50 needed his toenails cut and she was going to make him an appointment with a foot doctor, but she never had time to. Resident Grievance/Concern Follow-Up Form dated 8/6/25 taken from Resident Council at 10:30 AM (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documents Grievance/Concern was Would like toenails cut more often, Recommendation Cut toenails more often, and Efforts made by the facility to resolve the grievance and/or concern Staff educated and being checked with skin check. Resident Grievance/Concern Follow-Up Form dated 7/3/25 taken from Resident Council at 10:30 AM documents Grievance/Concern was Would like their toenails cut more often, Recommendation Educate staff on trimming nails on a regular basis, and Efforts made by the facility to resolve the grievance and/or concern CNA meeting held to review shower, shaves, and nail trimming, ensured materials were available, educate nurses as well to monitor compliance. On 8/20/2025 at 11:30 AM, Resident Council conducted during annual survey, residents stated toenails are still not good, they have given up on that and they try to do them themselves. A facility policy titled Care of Fingernails/Toenails dated October 2010 documents the purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. 3. R48's admission record documents an admission date of 09/13/24 with diagnoses including: cerebral infarction, dysphagia following cerebral infarction, dysarthria following cerebral infarction, anxiety disorder, quadriplegia, and schizophrenia. R48's minimum data sheet dated 07/24/25 documents a brief interview of mental status of 14 indicating cognitively intact. Section GG documents R48 is dependent for toileting and partial to moderate assistance for toilet transfers. The section titled, Bowel Continence documents R48 is always incontinent. On 08/20/25 at 7:50 AM, R48 was in the dining room eating breakfast. At 8:28 AM, R48 was in the dining room wet in his groin area from hip to hip to just past the top of his leg. At 8:43 AM, R48 was in his wheelchair near the exit of the dining room. At 8:48 AM, V19 (Certified Nursing Assistant) took R48 to his room. At 8:52 AM, R48 was laying in his bed and was still wet. At 9:00 AM, R48 was still in his bed wet. At 9:06 AM, R48 was still laying in his bed wet. At 9:21 AM, R48 was laying in his bed sleeping still wearing the same wet gray sweatpants. On 08/22/25 at 10:29 AM, V1 (Administrator) stated, if a resident was visibly wet in the dining room, she would not expect that staff interrupt their meal, unless the resident asked to be changed, but she would expect the resident to be taken and cleaned up right after they were done eating. She would not want them to be put to bed without them being cleaned up and changed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview and observation the facility failed to handle cups/glasses in a manner to prevent contamination for 2 (R38 and R48) of 6 residents reviewed for dining in a sample of 52. Findings include: On 08/19/25 at 7:50 AM, V17 (Certified Nurse Aide/CNA) delivered R48's drinks by transferring them by the rims where the resident would drink from, after touching a wheelchair handle and her scrub pants. On 08/19/25 at 8:13 AM, V18 (CNA) transferred R38's drinks from the tray to his table by the rim, where the resident would drink from, after touching a wheelchair handle and a resident's shirt. On 08/21/25 at 2:32 PM, V12 (Dietary Manager) stated drinks should not be transferred by the rims of the glasses where the residents drink from, especially after touching any unclean surface. V12 stated, he does not know who trains the CNAs or other staff for dietary procedures.		