STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146092	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Herrin	1900 North Park Avenue Herrin, IL 62948

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41610 Based on observation and interview the facility failed to provide a dignified and respectful dining experience by removing plates from the table while other residents are still eating for 4 (R30, R27, R16 and R18) of 4 residents reviewed for dignified dining. Findings include: On 09/18/24 at 12:25 PM, V10 (Dietary) was rolling a cart through the dining room with a white bucket (approximately 5 gallon size) on the cart and would pick up residents plates, scrape the leftover food into the bucket and stack the plates on the cart and place the silverware into another bucket. At the first table, R30 was finished while three residents were still eating. Right after V10 took R30's plate, R27 put her silverware down and rolled away from the table. At 12:27 PM, V10 went to the next table and removed R16's plate and glass, and R16 stated hey, I am not done with that. V10 gave her the glass back. There were three residents still eating at the table. V10 then attempted to take R18's plate and with her hand on the plate asked, are you finished, R18 stated, no, there were two residents still eating at the table. On 09/19/24 at 12:28 PM, V10 stated she has never been told not to pick up the resident's plates right away, so she will pick them up as soon as she sees someone that looks done and will take their plate no matter how many people are still eating at the table. V10 stated that makes sense to leave them as not to make the confused residents feel rushed. On 09/19/24 at 2:43 PM, V1 (Administrator) stated, she does not have a policy on dining cleaning procedures.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41610 Based on observation, interview and record review the facility failed to provide a clean and sanitary bathroom for 14 (R3, R24, R23, R14, R17, R21, R10, R22, R28, R29, R18, R19, R5 and R30) of 14 residents reviewed for environment in a sample of 32. The findings include: On 09/18/24 at 11:20 AM, the shower stall floor of the shower room on the B hall is cracked around the drain with the floor peeling away. There was an uneven cracked floor with large peeling area on the floor with areas of non-smooth peeling spots of over 2 feet by 2 feet, 6 inches by 5 inches, and mold around the bottom between the wall and the floor of the shower stall. There was a 2.5 inch gap between the wall and the floor on the right side of the toilet. In the front of the toilet in the second restroom on the B hall, there was a black accumulation around the bottom with an approximate 2 inch gap with approximately 0.25 inches of water accumulation. There is no restroom or shower room located on the C hall. On 09/18/24 at 11:51 AM, the room labeled men's bathroom on the B hall had an accumulation of dirt and debris causing an accumulation of a black substance approximately two inches out from in front of the toilet. On 09/19/24 at 12:02 PM, V1 (Administrator) stated the shower stall should be repaired and cleaned. The room roster dated 09/16/24 documents R3, R24, R23, R14, R17, R21, R10, R22, R28, R29, R18, R19, R5 and R30 reside on the B and C Halls and utilize the B Hall shower and restrooms. The facility policy dated 2021 titled, Maintenance Service documents: 2. Functions of maintenance personnel include but are not limited to: b. maintaining the building in good repair and free from hazards.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to prevent physical abuse of a resident from another resident with a known history of abuse for 1 of 3 residents (R16) reviewed for abuse in the sample of 32. The findings include: The Final IDPH (Illinois Department of Public Health) Incident and/or Abuse Notification, with an incident date of 9/20/23, documents, It was reported by staff that on 9/20/23 (R85) (resident) entered (R16's) (resident) room. (R16) loudly told her to leave her room. (R85) became startled and made contact with (R16). (R16) alerted nearby staff who immediately intervened and separated both residents. Nursing assessed both residents for any injuries. Slight bruising to (R16's) upper lip was noted. Nursing provided first aid to the affected area. (R85) was easily redirected and provided with additional activities. (R16) was provided with comfort and support. No further issues were noted Abuse is substantiated The Final IDPH Incident and/or Abuse Notification, with an incident date of 9/13/24, documents, An unwitnessed allegation involving a resident to resident altercation was reported by (R16) (resident). An investigation was initiated. It was reported by (R16) that (R85) (resident) made contact with her (R16) (resident) while in the dining room. (R16) stated that both residents separated themselves without any further issues. Nursing assessed both residents for any reddened areas or injuries. None were noted. (R85) is care planned for behaviors with impaired cognitive/thought processes. (R16) is care planned for delusional behavior and anxiety. These behaviors can impair both residents' ability to make good decisions and affects their safety awareness. This is an unwitnessed altercation with no injuries noted. (R85) is un-interviewable and cannot recall the incident (R85) and (R16) has a prior history of interactions. (R16) has delusional behaviors with anxiety and can fixate on past experiences. Based on these contributing factors along with a comprehensive investigation through staff and resident interviews, the IDT (Interdisciplinary Team) finds the allegation of abuse to be unsubstantiated . On 09/16/24 at 1:18 PM, R16 stated R85 gave me a bloody lip a few months ago. R16 stated yesterday or the day before (could not remember exact day), R85 tried to take a towel and her walker and R85 hit her in the arm and the mouth. R16's Progress Notes document the following: 9/13/24 at 6:04 PM, .Resident (R16) was hit in the mouth by another resident (R85). Incident unobserved by staff. Family informed. 9/16/24 at 12:26, Per Nurse - On 9/13/24 at approximately 18:12pm (6:12 PM) a resident-to-resident interaction occurred. The nurse immediately separated both residents and assessed them for signs and symptoms of injury, pain, or any other changes in clinical status. None were noted. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Integrity Hc of Herrin		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 North Park Avenue Herrin, IL 62948	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/16/24 the incident was identified this am and the nurse at the time did not report to the Administrators. Both residents were reassessed. No injuries noted. The administrator was immediately notified. An investigation was immediately implemented. On 9/19/24 at 7:52 AM, R7 stated she was with R16 in the dining room when R85 came up and started getting into stuff in R16's walker. R7 stated R16 asked her not to do that and R85 hit R16 in the shoulder and the mouth. R7 stated she couldn't remember the exact day, but it was one day last week. R7 stated she couldn't remember if staff were there when it happened but knows an unknown nurse came up to R16 after it happened. R7 stated R16 was ok and didn't appear injured. On 09/18/24 at 3:18 PM, V1 (Administrator) stated she was not notified of the allegation of abuse until she was reviewing notes on 9/16/24 and that is when she started an investigation. On 9/19/24 at 7:57 AM, this surveyor reviewed the abuse investigation for the incident that occurred on 9/13/24, with V1 (Administrator). V1 stated she was the one who did the abuse investigation for R16 and R85. When asked if she interviewed R16 she stated she did. V1 stated R16 did not report any witnesses to her. This surveyor shared with V1, R16 reported to this surveyor R7 witnessed the altercation. V1 stated she would have to speak to her corporate office and amend the investigation. V1 provided this surveyor with an amended Final IDPH Incident and/or Abuse Notification that documents, After a final report was made and investigation was completed, new evidence was presented to Administrator and investigation was re-opened. An allegation involving a resident to resident altercation was reported by (R16) (resident). An investigation was initiated. It was reported by (R16) that (R85) (resident) made contact with Her (resident) while in the dining room. (R16) stated that both residents separated themselves without any further issues In the original investigation no witnesses were found. But a resident has since voiced she witnessed the incident. The IDT reopened the investigation and has determined the allegation of abuse to be substantiated. This is the final report . R16's Admission Record with a print date of 9/18/24 documents R16 was admitted to the facility on [DATE] with diagnoses that include schizoaffective disorder, major depressive disorder, bipolar disorder, and anxiety disorder. R16's MDS (Minimum Data Set) dated 7/16/24 documents a BIMS (Brief Interview for Mental Status) score of 14, which indicates R16 is cognitively intact. R16's current Care Plan includes the Focus area of Abuse: (R16) is at risk for abuse and neglect r/t (related to) immobility Date Initiated 11/10/2021 The interventions documented for this Focus area include, 11/18/22 ask for assistance from staff when intervening with other residents and 2/11/22 (R16) will allow staff to redirect and intervene with other residents. R85's Admission Record with a print date of 9/19/24 documents R85 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, Alzheimer's disease, dementia, and bipolar disorder. R85's MDS (Minimum Data Set) dated 7/9/24 documents a BIMS (Brief Interview for Mental Status) score of 00, which indicates R85 has a severe cognitive deficit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R85's current Care Plan documents a Focus area of (R85) has a behavior problem r/t (related to) impulsive behaviors. (R85) is known to have physical behaviors such as hitting and kicking others, repetitive behaviors, pacing, slamming doors, packing items and exit seeking. (R85) also has a history of inappropriate touching. Date Initiated: 05/31/2023. The interventions documented for this Focus area include Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 05/31/2023 .Anticipate (R85's) needs. Date Initiated: 05/31/2023 .Assist (R85) to develop more appropriate methods of coping and interacting. Encourage (R85) to express feelings appropriately. Date Initiated: 05/31/2023 .Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 05/31/2023 . The facility Abuse Prevention Program-Policy dated 2022 documents, Residents have the right to be free from abuse, neglect, exploitations, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms Protection B. If the alleged perpetrator is a resident, the resident will be separated from the alleged victim and the resident's condition will be evaluated as soon as reasonably possible to determine the most suitable therapy and placement for the resident. This will be done taking in consideration the safety of other residents and employees of the facility

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility staff failed to report an allegation of resident to resident physical abuse to the Administrator immediately for 1 of 3 (R16) residents reviewed for abuse and neglect in the sample of 32. The findings include: The Final IDPH Incident and/or Abuse Notification date of incident 9/13/24 documents, An unwitnessed allegation involving a resident to resident altercation was reported by (R16) (resident). An investigation was initiated. It was reported by (R16) that (R85) (resident) made contact with Her (resident) while in the dining room. (R16) stated that both residents separated themselves without any further issues. Nursing assessed both residents for any reddened areas or injuries. None were noted. (R85) is care planned for behaviors with impaired cognitive/thought processes. (R16) is care planned for delusional behavior and anxiety. These behaviors can impair both residents' ability to make good decisions and affects their safety awareness. This is an unwitnessed altercation with no injuries noted. (R85) is un-interviewable and cannot recall the incident (R85) and (R16) has a prior history of interactions. (R16) has delusional behaviors with anxiety and can fixate on past experiences. Based on these contributing factors along with a comprehensive investigation through staff and resident interviews, the IDT (Interdisciplinary Team) finds the allegation of abuse to be unsubstantiated . On 09/16/24 at 1:18 PM, R16 stated R85 gave me a bloody lip a few months ago. R16 stated yesterday or the day before (could not remember exact day), R85 tried to take a towel and her walker and hit her in the arm and the mouth. R16's Progress Notes document the following: 9/13/24 at 6:04 PM, .Resident (R16) was hit in the mouth by another resident (R85). Incident unobserved by staff. Family informed. 9/16/24 at 12:26, Per Nurse - On 9/13/24 at approximately 18:12pm (6:12 PM) a resident-to-resident interaction occurred. The nurse immediately separated both residents and assessed them for signs and symptoms of injury, pain, or any other changes in clinical status. None were noted. 9/16/24 the incident was identified this am and the nurse at the time did not report to the Administrators. Both residents were reassessed. No injuries noted. The administrator was immediately notified. An investigation was immediately implemented. On 09/18/24 at 3:18 PM, V1 (Administrator) she was not notified of the allegation of abuse until she was reviewing notes on 9/16/24 and that is when she started an investigation. R16's Admission Record with a print date of 9/18/24 documents R16 was admitted to the facility on [DATE] with diagnoses that include schizoaffective disorder, major depressive disorder, bipolar disorder, and anxiety disorder. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's MDS (Minimum Data Set) dated 7/16/24 documents a BIMS (Brief Interview for Mental Status) score of 14, which indicates R16 is cognitively intact. R16's current Care Plan includes a Focus area of Abuse: (R16) is at risk for abuse and neglect r/t (related to) immobility. Date Initiated: 11/10/2021 The interventions documented for this Focus area include, 11/18/22 ask for assistance from staff when intervening with other residents and 2/11/22 (R16) will allow staff to redirect and intervene with other residents. R85's Admission Record with a print date of 9/19/24 documents R85 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, Alzheimer's disease, dementia, and bipolar disorder. R85's MDS (Minimum Data Set) dated 7/9/24 documents a BIMS (Brief Interview for Mental Status) score of 00, which indicates R85 has a severe cognitive deficit. R85's current Care Plan documents a Focus area of (R85) has a behavior problem r/t (related to) impulsive behaviors. (R85) is known to have physical behaviors such as hitting and kicking others, repetitive behaviors, pacing slamming doors, packing items and exit seeking. (R85) also has a history of inappropriate touching. Date Initiated: 05/31/2023. The interventions documented for this Focus area include Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 05/31/2023 .Anticipate (R85's) needs. Date Initiated: 05/31/2023 .Assist (R85) to develop more appropriate methods of coping and interacting. Encourage (R85) to express feelings appropriately. Date Initiated: 05/31/2023 .Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 05/31/2023 . The facility Abuse Prevention Program-Policy dated 2022 documents, .Internal Reporting. Employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must them immediately report it to the administrator

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview and record review, the facility failed to serve an appropriate non-emergent involuntary discharge and allow the resident and resident's family time to appeal the notice for 1 of 1 resident (R185) reviewed for discharge in the sample of 32. This failure resulted in R185 being removed from her environment and suffering psychosocial harm that any reasonable person would after being placed over two hours away from her family and friends without notice. The findings include: R185's Face sheet, dated 09/19/24, documents R185 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including cerebral infraction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified dementia severe with other behavioral disturbances, vascular dementia unspecified severity with other behavioral disturbances, anxiety, schizoaffective disorder, wandering in diseases classified elsewhere, bipolar II disorder, major depressive disorder recurrent, and cognitive communication deficit. R185's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 00, indicating R185 has severely impaired cognition. Section E documents no hallucinations or delusions, no physical behavioral symptoms directed towards others, no verbal behavioral symptoms, other behavioral symptoms not directed towards other (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 to 3 days out of the 7 day look back period, did not reject evaluation or care, and wandering 1 to 3 days out of the 7 day look back period. Section GG documents R185 was dependent for toileting, dressing, and personal hygiene and set-up and clean up for transfers. R185's Care Plan, with a cancelled date of 06/18/24, documents focus areas of: 1. (R185) is disoriented to place and time. (R185's) memory is similarly impaired. Consequently. (R185) has problems with decision-making, insight, logic, calculation, reasoning, planning, and judgement. (R185) is known to be impulsive at times. This problem it related to Dementia. Strengths and abilities include her ability to be easily redirected. 2. (R185) has a behavior problem r/t (related to) (R185) is known to wander and lacks safety awareness. (R185) is easily redirected by staff most of the time. (R185) has a hx. (History) of agitation r/t dementia. (R185's) son reports (R185) has a known trend of doing bad things out of defiance then laughing when confronted. Recently (R185) has started to defecate in inappropriate places. (R185) appears to like attention even when it is negative attention for doing wrong as reported by (R185's) son. 3. (R185) has no discharge potential r/t poor safety awareness, cognition, and inability to care for self. A documented goal for this focus was (R185) will remain in the facility long term. R185's Physician Orders document no order for discharge on 06/18/24 to another facility. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	R185's Progress Notes dated 06/14/24 at 8:16AM (Late entry) documents in part Called Her (R185's) son (V13) and left message that she (R185) was being moved. R185's Progress Note dated 06/18/24 at 7:01AM documents in part Resident (R185) discharged via facility transporter with personal clothing et (and) medications to receiving facility. R185's Progress Note dated 06/18/24 at 10:05AM documents SSD (Social Services Director/V3) mailed a letter to (R185's) son (V13) telling him where (R185) has been sent to and the address and phone number where (R185) can be reach [sic]. R185's Care Plan Summary/Participation record, dated 03/28/24, documents that R185 and V13 did not attend the meeting. Goals for care document D/C (Discharge) is feasible, but resident/responsible party goal remains for long term placement. Other changes/Updates document no family attended and Res (R185) will be looking at discharge to another facility when their lock down wing is complete. R185's Discharge Planning Review/Summary documents in part under Discharge Goals/General Information 1. Who initiated discharge? Resident (box checked). 2.Reason for discharge: She (R185) went to other facility. 3. Recap of resident's stay: The resident was a long-term resident that needed a locked down unit, and we transfer her to the other facility for better care .5. Initial discharge goals- remain in facility (box checked) . 8. Resident's goals of care and treatment preferences: to be able to stay in the facility. Under Medication Reconciliation it documents .2. Has post-discharge medication list been discussed with resident/family? Resident (box checked). Under Activity Summary, 1. Social Service it documents the Resident was excited that she was going to the [sic]. Under the section 2. Nursing Service it documents 1. Medical Summary-Medication was sent with her (R185). Under signatures 1. Resident signature and date documents R185 name typed in with date of 06/18/24. 3 staff signature documents V3 (Social Service Director) with typed in name and date of 06/18/24. On 09/18/24 at 8:50AM, V13 (Family Member) stated that the facility never contacted him about R185 moving to another facility. V13 said he received a phone call from an unknown number stating that it was a new facility, and they were admitting R185 and wanted to review R185's medication with him. V13 stated that he asked the new facility if R185 was at the other facility she had been at, and they stated no that R185 was transferred to them today from the other facility on 06/18/24. V13 said he was very upset and mad. V13 said that he told the new facility that no one had notified him that R185 had been discharged and moved. V13 said the new facility that she was transferred to was around 2 hours away from his house. V13 said the facility that R185 was in was only 15 minutes away from his house. V13 said he hasn't been able to visit often and that with covid and the fact that R185 doesn't know who he was most of the time was upsetting to him. V13 stated the facility did not notify him about R185 being transferred and there were no messages left regarding a transfer. V13 said the facility did talk to him about 3 or 4 months ago about maybe moving R185 to another facility, but they never said they were for sure moving her. V13 said the facility never mentioned any other facilities that they were thinking about moving R185 to that he could remember. V13 said they talked about discharging R185, but it was brief and nothing definite. V13 said the facility could of at least called him to let him know that R185 was moving. V13 said the facility calls him for all kinds of other things like when she has eloped, medication changes, and other stuff; why not when they transferred R185? V13 said that he did not receive any paperwork from the facility other than a bill and no information on where R185 went or information on her moving at all. V13 said that he would have preferred for R185 to stay at the facility, because it was closer to him. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	On 09/18/24 at 10:16AM, V14 (Facility Administrator at R185's new facility) stated that they did receive R185 as a new resident at their facility. V14 said that R185's old facility contacted them about 3-4 months ago and wanted to admit R185 to their facility. V14 said at that time they didn't have any beds available for R185. V14 said that they were in the middle of construction at that time for their locked unit and would have beds available soon. V14 doesn't remember off hand who she spoke to. V14 said they called the facility to let them know they had a bed available for R185. V14 said the facility worked on discharging R185 right away. V14 said when R185 was transferred to the new facility they did give all of R185's medical information. V14 said that R185 was admitted to a locked memory care unit at their facility. V14 said they did call V13 to verify R185's medications. V14 said that V13 was very upset and stated that he didn't know that R185 was discharged from the facility, and he knew nothing about R185 being admitted to a new facility. V14 said that V13 was very angry when they were talking to him because he was not made aware of any transfer or discharge. V14 said that R185 has seemed to adjust well to the new facility. V14 said that R185 did have some increased behaviors and some crying episodes at first, but that was expected some with her current diagnoses. V14 said that she didn't have a lot of concerns with R185 discharge and transfer other then V13 not knowing anything about the transfer and discharge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Herrin	1900 North Park Avenue Herrin, IL 62948

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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 0622 Level of Harm - Actual harm Residents Affected - Few	On 09/18/24 at 12:30PM V3 (Social Service Director/SSD) stated that the facility initiated R185's discharge. V3 said the facility initiated the discharge because they were unable to care for R185. V3 said R185 needed a locked facility because she kept trying to elope every day. V3 said the facility sent R185 to another facility that had a locked unit. V3 said they do have other resident that are elopement risks, but they don't usually get out like R185 did. V3 said they tried to do one on ones and extra activities but none of that worked. V3 said the one on one's didn't work, because R185 kept getting away from staff. V3 said R185 wouldn't stay with the person providing one on one's. V3 said the new facility has a locked unit and all we had was a medical alert device that the resident wears and locks the doors when she goes up to the door, but she would take off the medical alert device all the time. V3 said they determined the capability for care prior to admission by reviewing hospital or discharge records and talking to the family. V3 said she was not employed by the facility when R185 was admitted . V3 said that R185 has wandered since she has been employed by the facility. V3 said all of the elopement risk residents they have now have never actually eloped. V3 said the facility reviews discharge planning every three months on all residents, but most residents are long term. V3 said that R185 was sent to another facility that had a locked unit. V3 said R185's son V13 didn't have much to do with her. V3 said that she did try to contact V13 but was unable to get ahold of him. V3 said she tried several times to get a hold of V13 but was unable to get ahold of him to tell him that R185 was moving. V3 said that she did not document all the times she tried to get a hold of V13. V3 said she left messages, but V13 never returned her calls. V3 said she doesn't know why other staff were able to get a hold of V13 at times. V3 said V13 never called her back so she mailed him information telling him, where we sent R185 along with address and phone number of the new facility on the day R185 was discharged to other facility. V3 said that 3 months ago they did start talking about sending R185 to another facility. She said that V13 and R185 were invited to Care Plan and V13 never showed up. V3 said they had started working on the discharge then. V3 said she was not able to get ahold of V13 since the Care Plan meeting on 03/28/24. V3 doesn't remember how many times she attempted to call V13, but that she did leave him a message. V3 stated the discharge summary was not completed until 09/17/24. She stated that she did not know she had to complete a discharge summary when they transfer to another facility. V3 said she had started one on paper but got rid of it. V3 said she didn't know if there was a physician's order or not because that is something she doesn't deal with. V3 said it states on the discharge summary that R185 initiated discharge. V3 said R185 does have a BIMS score of 00 which indicates that R185 has severely impaired cognition, but that R185 is able to understand. V3 said that the BIMS score is 00 because R185 is nonverbal most of the time. V3 said she knows R185 understands, and she seemed happy about transferring to another facility. V3 said she believes that R185 was capable of making her own decisions. V3 said that she never attempted to contact any other family members on R185's contact list because they weren't the POA (Power of Attorney), and she was only told to get ahold of the POA. V3 said that she did not try to contact V13's wife who is also listed on R185's contact list. V3 stated that she thinks V1 (Administrator) or V2 (Director of Nursing) might have gotten ahold of V13 on the day R185 transferred, but she wasn't sure. V3 doesn't know if any forms were sent to V13 other than the information about the new facility she sent on the day of discharge on 06/18/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024

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F 0622 Level of Harm - Actual harm Residents Affected - Few	On 09/18/24 at 12:40PM, V1 (Administrator) stated that the facility did initiate R185's discharge when they sent her to a facility with a locked unit. V1 said that R185 was always escaping and trying to elope. V1 stated they do have other resident who are at risk for eloping, but that they have never gotten out. V1 said they have been planning the discharge for several months. V1 said that they were waiting for the other facility to have a room available for R185. V1 said that the other facility called and told them they had a bed available. V1 said that she did believe that a notice was sent to V13, but she didn't know when that was. V1 said that they did try to keep R185, she was placed on one on ones, but we couldn't do that forever. V1 said that R185 actually got out of the facility several times. V1 said they did do extra stuff like extra activities, small groups, one on ones, and a medical alert device that locks the doors. V1 said R185 was at the facility when she started. V1 said she knows that they did talk about notifying the son and she thought V3 took care of that. V1 said that V3 worked on R185's discharge planning. V1 doesn't know if there were any discharge orders or not, but she would look and see if she could find any orders. V1 said that she did call around to different facilities that are closer, but no one around could take her because they were full or just wouldn't take R185. V1 doesn't know if it was documented all the places that they tried to get ahold of to take R185. V1 said that they did notify R185 that they were transferring her to another facility. V1 said that R185 could understand and answer appropriately at times. V1 knows that R185 has a low BIMS score which indicates severely impaired cognition but V1 said that R185 knows what is going on. V1 said she would expect V13 to be notified of the discharge and transfer before it was made. V1 said that she didn't know what the policy was for involuntary facility-initiated discharges. On 09/19/24 at 7:55AM, V1 stated that they did not complete a notice of involuntary transfer form or notify the ombudsman concerning R185 involuntary facility-initiated discharge. V1 said at the time they were discharging R185 she wasn't thinking of it as an involuntary facility-initiated discharge. V1 stated that she does see that it was now. V1 stated that she does not know why V13 wasn't notified other than they could not get a hold of him. V1 said that they should have documented all the attempts the facility made to get a hold of V13, but she said they didn't. V1 agreed that V13 could not have done an appeal since he didn't know about the discharge. V1 said that she never told V3 that she could not call any of the other contact on R185's contact list other than the POA. V1 stated that V3 is still learning the Social Service Director job and probably didn't know she could have contacted others on R185's contact list. The Facility Policy titled Transfer or Discharge, Preparing a Resident for Discharge with a revision date of 12/2016 documents under Policy Statement Residents will be prepared in advance for discharge Policy Interpretation and Implementation documents in part 1a. Obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment. 1c. Providing the resident or representative (sponsor) with required documents. The Facility Policy titled Transfer or Discharge, Emergency revised 12/2016 documents in part under Policy Interpretation and Implementation 2. If a resident exercises his or her right to appeal a transfer or discharge notice he or she will not be transferred or discharged while the appeal is pending unless the failure to discharge or transfer would endanger the health and safety of the resident or other individuals in the facility. 3. If the resident is transferred or discharged despite his or her pending appeal, the danger that failure to transfer or discharge would pose will be documented. 4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, home, or other setting our facility will implement the following procedures. 4a. Notify the resident's attending physician . 4e. Notify the representative (Sponsor) or other family member. (continued on next page)

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	146092	A. Building B. Wing	09/23/2024

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F 0622 Level of Harm - Actual harm Residents Affected - Few	The facility policy titled Discharge Summary and Plan revised 12/2016 documents under Policy Statement When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new environment. Under Policy Interpretation and Implementation it documents 12. A member of the IDT (Interdisciplinary Team) will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. 13. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge summary.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview and record review the facility failed to provide a resident or representative and the Ombudsman with a written notice of discharge with appeal rights for 1 of 1 resident (R185) reviewed for discharge in the sample of 32. The Findings include: R185's Face sheet, dated 09/19/24, documents R185 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including cerebral infraction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified dementia severe with other behavioral disturbances, vascular dementia unspecified severity with other behavioral disturbances, anxiety, schizoaffective disorder, wandering in diseases classified elsewhere, bipolar II disorder, major depressive disorder recurrent, and cognitive communication deficit. R185's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 00, indicating R185 has severely impaired cognition. Section E documents no hallucinations or delusions, no physical behavioral symptoms directed towards others, no verbal behavioral symptoms, other behavioral symptoms not directed towards other (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 to 3 days out of the 7 day look back period, did not reject evaluation or care, and wandering 1 to 3 days out of the 7 day look back period. Section GG documents R185 was dependent for toileting, dressing, and personal hygiene and set-up and clean up for transfers. R185's Care Plan, with a cancelled date of 06/18/24, documents focus areas of: 1. (R185) is disoriented to place and time. (R185's) memory is similarly impaired. Consequently. (R185) has problems with decision-making, insight, logic, calculation, reasoning, planning, and judgement. (R185) is known to be impulsive at times. This problem it related to Dementia. Strengths and abilities include her ability to be easily redirected. 2. (R185) has a behavior problem r/t (related to) (R185) is known to wander and lacks safety awareness. (R185) is easily redirected by staff most of the time. (R185) has a hx. (History) of agitation r/t dementia. (R185's) son reports (R185) has a known trend of doing bad things out of defiance then laughing when confronted. Recently (R185) has started to defecate in inappropriate places. (R185) appears to like attention even when it is negative attention for doing wrong as reported by (R185's) son. 3. (R185) has no discharge potential r/t poor safety awareness, cognition, and inability to care for self. A documented goal for this focus was (R185) will remain in the facility long term. R185's Progress Notes dated 06/14/24 at 8:16AM (Late entry) documents in part Called Her (R185's) son (V13) and left message that she (R185) was being moved. R185's Progress Note dated 06/18/24 at 10:05AM documents SSD (Social Services Director/V3) mailed a letter to (R185's) son (V13) telling him where (R185) has been sent to and the address and phone number where (R185) can be reach [sic]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Integrity Hc of Herrin		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 North Park Avenue Herrin, IL 62948	

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R185's Care Plan Summary/Participation record for R185, dated 03/28/24, documents in part R185 and V13 did not attend meeting. Goals for care document D/C (Discharge) is feasible, but resident/responsible party goal remains for long term placement. Other changes/Updates document no family attended. R185 (Res) will be looking at discharge to another facility when their lock down wing is complete. R185's Discharge Planning Review/Summary documents in part under Medication Reconciliation 2. Has post-discharge medication list been discussed with resident/family? R185 (Resident). Under signatures 1. Resident signature and date documents R185 name typed in with date of 06/18/24. 3 staff signature documents V3 (Social Service Director) with typed in name and date of 06/18/24. On 09/18/24 at 8:50AM, V13 (Family Member) stated that the facility never contacted him about R185 moving to another facility. V13 said he received a phone call from an unknown number stating that it was a new facility, and they were admitting R185 and wanted to review R185's medication with him. V13 stated that he asked the new facility if R185 was at the other facility she had been at, and they stated no that R185 was transferred to them today from the other facility on 06/18/24. V13 said he was very upset and mad. V13 said that he told the new facility that no one had notified him that R185 had been discharged and moved. V13 said the new facility that she was transferred to was around 2 hours away from his house. V13 said the facility that R185 was in was only 15 minutes away from his house. V13 said he hasn't been able to visit often and that with covid and the fact that R185 doesn't know who he was most of the time was upsetting to him. V13 stated the facility did not notify him about R185 being transferred and there were no messages left regarding a transfer. V13 said the facility did talk to him about 3 or 4 months ago about maybe moving R185 to another facility, but they never said they were for sure moving her. V13 said the facility never mentioned any other facilities that they were thinking about moving R185 to that he could remember. V13 said they talked about discharging R185, but it was brief and nothing definite. V13 said the facility could of at least called him to let him know that R185 was moving. V13 said the facility calls him for all kinds of other things like when she has eloped, medication changes, and other stuff; why not when they transferred R185? V13 said that he did not receive any paperwork from the facility other than a bill and no information on where R185 went or information on her moving at all. V13 said that he would have preferred for R185 to stay at the facility, because it was closer to him. On 09/18/24 at 10:16AM, V14 (Facility Administrator at R185's new facility) stated that they did receive R185 as a new resident at their facility. V14 said that R185 was admitted to a locked memory care unit at their facility. V14 said they did call V13 to verify R185's medications. V14 said that V13 was very upset and stated that he didn't know that R185 was discharged from the facility, and he knew nothing about R185 being admitted to a new facility. V14 said that V13 was very angry when they were talking to him because he was not made aware of any transfer or discharge. V14 said that R185 has seemed to adjust well to the new facility. V14 said that R185 did have some increased behaviors and some crying episodes at first, but that was expected some with her current diagnoses. V14 said that she didn't have a lot of concerns with R185's discharge and transfer other then V13 not knowing anything about the transfer and discharge. (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 12:30PM, V3 (Social Service Director/SSD) stated that the facility initiated R185's discharge. V3 said that R185 was sent to another facility that had a locked unit. V3 said that she did try to contact V13 but was unable to get ahold of him. V3 said she tried several times to get a hold of V13 but was unable to get ahold of him to tell him that R185 was moving. V3 said that she did not document all the times she tried to get a hold of V13. V3 said she left messages, but V13 never returned her calls. V3 said she doesn't know why other staff were able to get a hold of V13 at times. V3 said V13 never called her back so she mailed him information telling him, where we sent R185 along with address and phone number of the new facility on the day R185 was discharged to other facility. V3 said that 3 months ago they did start talking about sending R185 to another facility. She said that the V13 and R185 were invited to Care Plan and V13 never showed up. V3 said they had started working on the discharge then. V3 said she was not able to get ahold of V13 since the Care Plan meeting on 03/28/24. V3 doesn't remember how many times she attempted to call V13, but that she did leave him a message. V3 said it states on the discharge summary that R185 initiated discharge. V3 said R185 does have a BIMS score of 00 which indicates that R185 has severely impaired cognition, but that R185 is able to understand. V3 said that the BIMS score is 00 because R185 is nonverbal most of the time. V3 said she knows R185 understands, and she seemed happy about transferring to another facility. V3 said she believes that R185 was capable of making her own decisions. V3 said that she never attempted to contact any other family members on R185 contact list because they weren't the POA (Power of Attorney), and she was only told to get ahold of the POA. V3 said that she did not try to contact V13's wife who is also listed on R185's contact list. V3 stated that she thinks V1 (Administrator) or V2 (Director of Nursing) might have gotten ahold of V13 on the day R185 transferred, but she wasn't sure. V3 doesn't know if any forms were sent to V13 other than the information about the new facility she sent on the day of discharge on 06/18/24. On 09/18/24 at 12:40PM, V1 (Administrator) stated that the facility did initiate R185's discharge. They sent her to a facility with a locked unit. V1 said that she did believe that a notice was sent to V13, but she didn't know when that was. V1 said she knows that they did talk about notifying the son. She thought V3 took care of that. V1 said that V3 worked on R185's discharge planning. V1 said that R185 could understand and answer appropriately at times. V1 knows that R185 has a low BIMS score which indicates severely impaired cognition but V1 said that R185 knows what is going on. V1 said she would expect V13 to be notified of the discharge and transfer before it was made. V1 said that she didn't know what the policy was for involuntary facility-initiated discharges. On 09/19/24 at 7:55AM, V1 stated that they did not complete a notice of involuntary transfer form or notify the ombudsman concerning R185's involuntary facility-initiated discharge. V1 said at the time they were discharging R185 she wasn't thinking of it as an involuntary facility-initiated discharge. V1 stated that she does see it was now. V1 stated that she does not know why V13 wasn't notified other then they could not get a hold of him. V1 said that they should of documented all the attempts the facility made to get a hold of V13, but she said they didn't. V1 agreed that V13 could not have done an appeal since he didn't know about the discharge. V1 said that she never told V3 that she could not call any of the other contacts on R185's contact list other than the POA. V1 stated that V3 is still learning the Social Service Director job and probably didn't know she could have contacted others on R185 contact list. On 09/19/24 at 3:30PM, V1 stated that she could not find a policy regarding Involuntary Facility Initiated Non-Emergent discharges. (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Policy titled Transfer or Discharge, preparing a Resident for Discharge with a revised date of 12/2016 documents under Policy statement Residents will be prepared in advance for discharge Policy Interpretation and Implementation documents in part 1c. Providing the resident or representative (sponsor) with required documents. The Facility Policy titled Transfer or Discharge, Emergency revised 12/2016 documents in part under Policy interpretation and Implementation 2. If a resident exercises his or her right to appeal a transfer or discharge notice, he or she will not be transferred or discharged while the appeal is pending unless the failure to discharge or transfer would endanger the health and safety of the resident or other individuals in the facility. 3. If the resident is transferred or discharged despite his or her pending appeal, the danger that failure to transfer or discharge would pose will be documented. 4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, home, or other setting our facility will implement the following procedures. 4a. Notify the resident's attending physician. 4e. Notify the representative (Sponsor) or other family member. The facility policy titled Discharge Summary and Plan revised 12/2016 documents under policy statement When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new environment. Under Policy Interpretation and Implementation 12. A member of the IDT (Interdisciplinary Team) will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. 13. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan: and c. The discharge summary.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview and record review the facility failed to provide a discharge summary for 1 of 1 resident (R185) reviewed for discharge in a sample of 32. The findings include: R185's Face Sheet, with a print date of 09/19/24, documents R185 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including cerebral infraction due to unspecified occlusion or stenosis of unspecified cerebral artery, unspecified dementia severe with other behavioral disturbances, vascular dementia unspecified severity with other behavioral disturbances, anxiety, schizoaffective disorder, wandering in diseases classified elsewhere, bipolar II disorder, major depressive disorder recurrent, and cognitive communication deficit. R185's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 00, indicating R185 has severely impaired cognition. Section E documents no hallucinations or delusions, no physical behavioral symptoms directed towards others, no verbal behavioral symptoms, other behavioral symptoms not directed towards other (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 to 3 days out of the 7 day look back period, did not reject evaluation or care, and wandering 1 to 3 days out of the 7 day look back period. Section GG documents R185 was dependent for toileting, dressing, and personal hygiene and set-up and clean up for transfers. R185's Care Plan, with a cancelled date of 06/18/24, documents focus areas of: 1. (R185) is disoriented to place and time. (R185's) memory is similarly impaired. Consequently. (R185) has problems with decision-making, insight, logic, calculation, reasoning, planning, and judgement. (R185) is known to be impulsive at times. This problem it related to Dementia. Strengths and abilities include her ability to be easily redirected. 2. (R185) has a behavior problem r/t (related to) (R185) is known to wander and lacks safety awareness. (R185) is easily redirected by staff most of the time. (R185) has a hx. (History) of agitation r/t dementia. (R185's) son reports (R185) has a known trend of doing bad things out of defiance then laughing when confronted. Recently (R185) has started to defecate in inappropriate places. (R185) appears to like attention even when it is negative attention for doing wrong as reported by (R185's) son. 3. (R185) has no discharge potential r/t poor safety awareness, cognition, and inability to care for self. A documented goal for this focus was (R185) will remain in the facility long term. R185's Progress Note dated 06/18/24 at 7:01AM documents in part Resident discharged via facility transporter with personal clothing et (and) medication to receiving facility. R185's Care Plan Summary/Participation record for R185, dated 03/28/24, documents in part R185 and V13 did not attend meeting. Goals for care document D/C (Discharge) is feasible, but resident/responsible party goal remains for long term placement. Other Changes/Updates document no family attended. Res (R185) will be looking at discharge to another facility when their lock down wing is complete. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R185's Discharge Planning Review/Summary documents in part under Discharge Goals/General Information 1. Who initiated discharge? Resident (box checked). 2.Reason for discharge: She (R185) went to other facility. 3. Recap of resident's stay: The resident was a long-term resident that needed a locked down unit, and we transfer her to the other facility for better care .5. Initial discharge goals- remain in facility (box checked) . 8. Resident's goals of care and treatment preferences: to be able to stay in the facility. Under Medication Reconciliation it documents .2. Has post-discharge medication list been discussed with resident/family? Resident (box checked). Under Activity Summary, 1. Social Service it documents the Resident was excited that she was going to the [sic]. Under the section 2. Nursing Service it documents 1. Medical Summary-Medication was sent with her (R185). Under signatures 1. Resident signature and date documents R185 name typed in with date of 06/18/24. 3 staff signature documents V3 (Social Service Director) with typed in name and date of 06/18/24. On 09/18/24 at 12:30PM, V3 (Social Service Director/SSD) stated the discharge summary was not completed until 09/17/24 she stated that she did not know she had to complete a discharge summary when they transfer to another facility. V3 said she had started one on paper but got rid of it. The facility policy titled Discharge Summary and Plan revised 12/2016 documents under policy statement When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new environment. Under Policy Interpretation and Implementation 12. A member of the IDT (Interdisciplinary Team) will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place . 13. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan: and c. The discharge summary.

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NAME OF PROVIDER OR SUPPLIER: Integrity Hc of Herrin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1900 North Park Avenue Herrin, IL 62948	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on observation, interview and record review the facility failed to follow physician's orders as prescribed for one (R14) of one resident reviewed for respiratory concerns in a sample of 32. The findings include: R14's face sheet documents an admitted [DATE] with diagnoses including: chronic obstructive pulmonary disease, moderate persistent asthma with (acute) exacerbation, dementia, and anxiety disorder. R14's Nurse's Note dated 09/14/24 at 4:23 PM documents: R14 came up to this nurse and stated, I don't feel well at all. This nurse asked the resident what was wrong, and she stated, I cannot stop coughing and I feel SOB (short of breath). This nurse assessed R14 and R14 has wheezing noted in all lung fields. The resident has some shortness of breath and a nonproductive cough that has been constant. R14 expresses that she is very tired as well. Covid test is negative. Vital signs are as follows: T (temperature) 97.5 (degrees Fahrenheit) P (pulse) 86, R (respirations) 20, BP (blood pressure) 151/82, and O2 (oxygen) 95% on 4L (liters). V15 (Medical Physician) notified of the above information and awaiting response at this time. The plan of care is ongoing. R14's Nurse's Note dated 09/14/24 at 5:46 PM documents: V15 responded back and stated, get a chest x-ray, start Prednisone 40 mg for 5 days and Duoneb q (every) 6 (hours) PRN (as needed). The orders are noted and processed. The plan of care is ongoing. R14's Physician's Order Sheet documents an order for Ipratropium-Albuterol solution (Duoneb) 0.5-2.5 (3) MG (milligrams)/3ML (milliliters) with an order date of 09/14/2024 and a start date of 09/16/24. R14's Physician's Order Sheet documents an order for Prednisone 40 milligrams with an order date of 09/14/2024 and a start date of 09/16/24. R14's Medication Administration Record (MAR) documents the first administration of Prednisone was 09/16/24. R14's MAR documents there was no administration of Ipratropium-Albuterol solution 0.5-2.5 (3) MG/3ML as of 09/19/24. R14's Nurse's Note dated 09/16/24 at 12:48 AM documents: R14's CXR (chest x-ray) shows that she has PNA (pneumonia) and will start abx (antibiotic) today, as well as Prednisone. R14's O2 sat (oxygen saturation) on 3 lpm (liters per minute) was 88%. O2 (oxygen) was increased to 4 lpm, the O2 sat is now 92%. No s/sx (signs or symptoms) of distress. There is no sob (shortness of breath), her HOB (head of the bed) was elevated 30 degrees. Will monitor. On 09/16/24 at 8:35 AM, R14 stated she was short of breath and on oxygen at 4 liters. R14 asked (surveyor) if her oxygen could be turned up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/16/24 at 8:35 AM, R14 was having labored breathing and was short of breath. R14 was showing abdominal breathing. The surveyor notified the nurse at this time. On 09/16/24 at 8:37 AM, V2 (Director of Nursing) was observed entering R14's room to assess her. As of 09/19/24 there was no Nurse's Note or assessment available in R14's Electronic Health Record documenting V2's assessment. On 09/18/24 at 11:07 AM, V6 (Registered Nurse) stated R14's Prednisone and Ipratropium-Albuterol nebulizer were not started until 09/16/24. V6 stated, he does not see anywhere why they held the order until the 09/16 when he can see the order came in on 09/14. On 09/18/24 at 11:42 AM, V2 stated, she did not know why the Prednisone and the Ipratropium-Albuterol solution was started on 09/16/24 instead of 09/14/24. She stated she would have to ask V16 (Licensed Practical Nurse) if V15 (Medical Physician) wanted the medication held for some reason. On 09/19/24 at 9:40 AM, V2 stated she had not heard from V16 yet. On 09/19/24 at 1:40 PM, R14 was laying in her bed, she was having difficulty breathing and was short of breath. Her abdomen was sharply rising and falling while she was trying to breathe, and she was having difficulty with conversation. R14 stated, she was still having difficulty breathing. This surveyor notified V6 (Registered Nurse) at this time. There was no Nurse's Note or assessment available in R14's Electronic Medical Record of an assessment being completed on 9/19/24. On 09/20/24 at 8:50 AM, V15 stated he ordered the Prednisone and the Ipratropium-Albuterol on 09/14/24 for shortness of breath and he was expecting it to be given on 09/14/24, he would not have expected either of those medications to be held and not given until 09/16/24. He stated he ordered a chest x-ray on 09/14/24 which he received the results for on 09/15/24 and ordered an antibiotic for pneumonia that was started on the 16th, but he didn't want to give the antibiotic until he knew she had pneumonia for sure. On 09/23/24 at 10:33 AM, V2 stated she did not know why R14 had not received the Ipratropium-Albuterol nebulizer treatment or the prednisone on the 14th, she stated she has not been able to talk to V16. On 09/23/24 at 10:33 AM V1 (Administrator) stated, she did know why R14 had not received the Ipratropium-Albuterol nebulizer treatment or the prednisone on the 14th. R14's Care Plan documents an undated focus area of: Respiratory: potential for respiratory complications r/t (related to) recent acute respiratory failure, asthma with status asthmaticus, asthma with exacerbation and comorbidity of obesity with undated interventions listed as: administer medications as ordered, administer oxygen as ordered, and assess respiratory status: rate, depth, pattern, and skin color. The facility policy dated January 2024 titled, Administering Medications documents: 3. Medications must be administered in accordance with the orders, including any required time frame.

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F 0692 Level of Harm - Minimal harm or potential for 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** 41610 Based on observation, interview, and record review the facility failed to provide supplements as ordered and follow the facility policy for weight management for 2 (R27 and R15) of 4 residents reviewed for nutrition in a sample of 32. Findings include: 1. R27's face sheet documents an admitted [DATE] with diagnoses including: unspecified physeal fracture of lower end of right fibula, dementia, muscle weakness, and chronic kidney disease. R27's Minimum Data Set (MDS) dated [DATE] documents: a Brief Interview for Mental Status of 04, indicating R27 has severe cognitive impairment, section GG documents eating assistance is: supervision or touching assistance. R27's Physician Order Sheet documents a dietary order of: regular diet with mechanical soft texture, and thin liquids with an order date of 08/06/24 and no end date listed. R27's weights are documented as: 8/6/2024 at 2:57 PM: 118.0 Lbs (pounds), 8/8/2024 at 3:56 PM: 118.0 Lbs, 8/22/2024 at 5:45 PM: 100.0 Lbs, 8/23/2024 at 2:14 PM: 99.5 Lbs, and 9/5/2024 at 10:26 AM: 100.4 Lbs. R27's Dietary Notes dated 8/27/2024 at 2:37 PM document: Initial Nutritional Review: R27's weight 99.5# (pounds), her diet order is regular diet with mechanical soft texture. R27's weights reflect a 15.7% weight loss since admission, her current weight is within IBW (Ideal Body Weight) range. R27's BMI (Body Mass Index) is 18.8 %. Her intake is reported as 50%-100% of most documented meals. R27 is currently COVID positive status. No labs are currently available for review. There are no skin concerns reported. R27's estimated nutrient needs are 1260 kcals (kilocalories)/day, 45 grams protein/day and 1350 ml (milliliters) fluid/day. (V17-Registered dietician) recommend's health shake with meals to provide additional nutritional support. R27's Nurse's Note dated 08/21/24 at 3:51 PM documents: R27 is COVID positive on 08/19/24. On 09/17/24 at 12:20 PM, R27 attempted to take a drink of her health shake through her straw, and none came up, she put the carton down and started moving away from the table. On 09/17/24 at 12:23 PM, R27's health shake was frozen with a straw in it and there was a full carton still present. On 09/17/24 at 12:23 PM V2 (Director of Nursing) stated, they need to get those health shakes thawed. On 09/18/24 at 2:20 PM, V1 (Administrator) stated their policy states, residents should be weighed weekly as a new admission, she does not know why R27 was not weighed on 08/14 or 08/15. If she had weight loss, then V17 should have been notified. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/23/24 at 10:35 AM, V1 stated she does not know why there is not an order for a health shake for R27. On 09/23/24 at 10:35 AM, V2 stated, she did have a weight for R27 on 08/13/24 of 107.5 pounds, it was written in a notebook. She stated, she does have R27 at 118 pounds on 08/06/24 that would have triggered a significant weight loss for R27. R27's Electronic Health Record does not contain any documentation of a weight for R27 on 08/13/24 or any documentation of notification of V17 of R27's weight loss on 08/13/24. 2. R15's Face Sheet documents an admitted [DATE] with diagnoses including: anemia, muscle weakness, vitamin D deficiency, and other fatigue. R15's MDS date 08/30/24 documents no BIMS score listed. Section C documents: cognitive skills for daily decision making as: moderately impaired. R15's Physician's Order Sheet documents a dietary order for: regular diet, regular texture with thin liquids consistency, super cereal daily, med pass 2.0 60 cc (cubic centimeters) TID (three times a day) with meals, extra dessert at lunch for dietary with an order date of 09/04/2024 and no end date listed. R15's Physician's Order Sheet documents an order for: admit to residential hospice with a start date of 09/04/24 with no end date listed. R15's Care Plan (undated) documents a Focus area of (R15) is under Hospice care due to a terminal diagnosis of Atherosclerosis of native coronary artery. On 09/17/24 at 12:13 PM, R15 did not receive extra dessert with lunch. On 09/18/24 at 12:10 PM, R15 did not receive extra dessert with lunch. On 09/19/24 at 12:15 PM, R15 did not receive an extra dessert at lunch. R15 stated, he only gets one dessert with lunch. At this time, R15 was alert and oriented to person, place and time. R15's Nurse's Notes dated 8/1/2024 at 12:08 PM document: R15 is noted with weight loss, a new order for extra dessert at lunch. R15's Dietary Notes dated 6/17/2024 at 7:48 PM documents: R15 was reweighed at 128#(pounds) which is stable with his usual weight, weight is maintained within IBW range. R15's intake is reported as 50%-100% of documented meals. Continue with present diet order of Regular with super cereal at breakfast and med pass 2.0 60cc tid and weigh monitoring. R15's Dietary Notes dated 7/30/2024 at 6:42 AM documents: Annual Nutritional Review: R15's weight 133# (pounds) his diet order is: regular diet; super cereal at breakfast; and med pass 2.0 60cc tid. R15's weight is within IBW range and BMI is 22.1 %, his intake varies between 50%-100% of most meals. There are no labs currently available for review. There are No skin concerns reported. R15's estimated nutrient needs are 1680 kcals/day, 60 grams protein/day and 1800 ml fluid/day. R15's diet is appropriate to provide for estimated needs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's weights are documented as: 02/12/24 at 9:53 AM as 145.0 Lbs (pounds), 03/11/24 at 10:19 AM as 145 Lbs, 04/25/24 at 2:48 PM 132.5 Lbs, 04/29/24 at 12:29 PM as 130.5 Lbs, 05/27/2024 at 2:32 PM as 128 Lbs, 06/11/24 at 10:13 AM as 123 Lbs, 07/29/24 at 2:20 PM as 133 Lbs, and 08/12/24 at 10:19 AM as 129 Lbs. On 09/19/24 at 2:37 PM, V17 (Registered Dietician) stated, she would expect to be notified of any significant weight loss and she would expect all residents to receive supplements that are ordered, and, in a manner, they can consume them or to be given assistance to consume them. On 09/23/24 at 10:35 AM V2 stated, that R15 had an incorrect weight entered in R15's weight record and it threw off R15's weight triggers. Therefore R15 would have triggered a weight loss and not triggered for a weight gain, thus showing V17 that R15 had a significant weight loss. The facility policy dated 2023 titled, Weight Assessment and Intervention documents: Weight Assessment: 1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weight will be measured monthly thereafter. 3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 4. The dietitian will review the unit weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on observation, interview and record review the facility failed to provide diets as ordered for 2 (R18 and R24) of 4 residents reviewed for nutrition in a sample of 32. The findings include: R18's face sheet documents an admitted [DATE] with diagnoses including: dementia and diastolic heart failure. R18's Physician's Order Sheet documents an order for: regular diet with mechanical soft texture, thin liquid consistency, cut meats, super cereal, and snack between meals. Ice cream at lunch and supper. Extra dessert at lunch and supper, health shakes twice daily after breakfast and after lunch with an order date of 07/22/2024 and no end date listed. R18's care plan documents an undated focus area of: R18 is as risk for comprised nutritional status related to Diagnosis of Alzheimer's disease or related dementia. R18 is on a mech (sic) soft regular diet per her request as she has difficulty at times chewing meats with her partial dentures with an undated intervention of regular mech soft diet, cut meats and super cereal, ice cream for lunch and supper. R24's face sheet documents an admitted [DATE] with diagnoses including: dementia, Alzheimer's disease, and prediabetes. R24's Physician's Order Sheet documents an order for NAS (no added salt) diet with mechanical soft texture, thin liquids consistency, assist resident as needed with meals, Finger food at mealtimes. Resident to use plastic cutlery for safety. No napkin. 60 cc (cubic centimeters) of 2.0 daily with lunch. Health shakes three times daily with meals. Extra sauces and gravy with an order date of 08/09/2024 and no end date listed. R24's care plan documents an undated focus area of nutrition; R24 is at risk for complications with weight and nutrition r/t (relating to) dementia. R24 is on a NAS regular texture diet with undated interventions listed include: diet: NAS mechanical soft with thin liquids. The facility document dated day 18 Wednesday titled, Diet Spreadsheet documents: regular diet: crispy rice dessert bar 3 (inch) x 2-1/2 and the dental soft (Mech soft) diet documents: soft sugar cookies - 2 cookies. On 09/18/24 at 12:10 PM, R18 received the crispy rice dessert bar for lunch. R18 took a small bite of the crispy rice bar tried to chew for a bit and did not try to eat the rest. R24 received the crispy rice dessert bar for lunch. R24 took a bite of the crispy rice bar, chewed for a bit and sounded like he cleared his throat and got up and started walking over to another table. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/24 at 2:37 PM, V17 (Registered Dietician) stated she would expect all residents to receive the diet they are ordered, so the mechanical soft diet should get all the items that are included with the specific diet texture, including the dessert. The facility policy dated 2022 titled, Therapeutic Diets documents: 1. Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered therapeutic diets.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure transmission based precautions were implemented, and failed to ensure hand hygiene was performed per current standards of practice for 2 of 6 (R85 and R3) residents reviewed for infection control in the sample of 32. Findings Include: R85's Admission Record with a print date of 9/19/24 documents R85 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, Alzheimer's disease, dementia, and bipolar disorder. R85's MDS (Minimum Data Set) dated 7/9/24 documents a BIMS (Brief Interview for Mental Status) score of 00, which indicates R85 has a severe cognitive deficit. R85's Order Summary Report dated 9/19/24 documents a physician order with a start date of 9/11/24 of Transmission based precautions until 9/22/2024 R85's current Care Plan documents a Focus area of (R85) has tested positive for Covid 19. Date Initiated: 09/10/2023. Revision on: 09/12/2024. This Focus area includes the following interventions.Administer medications as ordered. Monitor for potential side effects and effectiveness. Date Initiated: 09/12/2024 Contact/droplet isolation precautions per protocol. Date Initiated: 09/12/2024 . R85's Progress Notes document the following: 9/6/24 9:24 AM, Staff told nurse that resident has been acting different . resident is very lethargic. Opening her eyes but not responding. Resident is usually walking around building all day and is currently laying in bed with no response. Resident is usually aggressive with care but isn't even responding to care at this time. Resident is shaky and clammy to touch. Vital signs are as followed: T (temperature) 98.4, P (pulse) 91, O2 (oxygen) 97%, BP (blood pressure) 101/61, R (respirations) 18. Blood sugar is 155. Covid test negative . (name of physician) stated, send resident to ER (emergency room) for further evaluation. 9/6/24 7:15 PM, Call received from (name of local hospital) stating resident is being admitted there with DX (diagnosis): Pneumonia. 9/7/24 9:35 AM, Called (name of hospital) for update on Resident, nurse stated that resident is doing ok, they are monitoring her respiratory symptoms, stating she is having some wheezing and SOB (shortness of breath), they also stated that resident is positive for Covid-19. 9/10/24 3:56 PM, .Res (resident) just arrived back to the facility via EMS (emergency medical services) Res vital signs are T 99.0, P 89, R 16, BP 90/44, O2 95% on room air . 9/11/24 9:46 PM, Resident has been up ambulating independently about facility w/o (without) gait disturbance noted Resident is on transmission-based precautions r/t (related to) dx (diagnosis) of covid 19 positive while in (name of local hospital) (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/12/24 8:02 AM, .Res up in the dining room eating breakfast at this time. Res ambulating this morning with no problems . 9/12/24 10:48 PM, . Resident walked around the facility as usual. Offered snacks throughout the shift . 9/15/24 8:32 AM, The resident is up in the dining room ambulating around. Res has no complaints at this time. No signs or symptoms of distress or discomfort. Plan of care on going. On 9/16/24 at 12:24 PM, R85 walked through the dining room, carrying her dessert of apple crisp, eating it with her fingers. R85 stopped at a table where peers were sitting and continued eating her dessert. R85 then walked to a second table of peers and stood eating her dessert. R85 set her dessert on the table near R4's dessert. An unknown certified nursing assistant walked R85 to a different table, had R85 sat down, and assisted her to eat her meal. R85's dessert was left on R4's table near his dessert. At no time throughout these observations did staff encourage R85 to eat in her room, wear a mask, or keep her distance from peers. On 9/17/24 at 12:12 PM, R85 stood in the dining room within two feet of peers with no mask on and staff did not encourage R85 to go to her room or don a mask. At 12:13 PM, R85 walked to V2 (Director of Nurse) office and stood. V2 walked past R85 and did not encourage her to wear a mask or go to her room. V3 (Social Services Director) assisted R85 to adjust her pants and did not encourage R85 to wear a mask or go to her room. R85 then walked down the hall her room was located on. On 9/18/24 at 4:38 PM, V2 (Director of Nurses) stated R85 returned from a hospital stay and it was reported to the facility R85 tested positive for Covid 19 while at the hospital. V2 stated they were never given any lab report documenting the positive test, but they placed R85 on isolation precautions since it was reported to them, she had tested positive. This surveyor shared the observation of R85 eating in the dining room and being in the dining room throughout the survey process without a mask on and no staff observed encouraging R85 to wear a mask or eat in her room. V2 stated she would think staff should encourage R85 to stay in her room and/or wear a mask if she was out and about in the facility. On 9/19/24 at 10:25 AM, this surveyor walked through the dining room following V2. R85 was sitting at a table, with peers, eating a cookie. This surveyor asked V2 if R85 was off isolation. V2 got V15 (Licensed Practical Nurse) and asked her to encourage R85 to go to her room or put a mask on. The undated facility Infection Control Policy Covid 19 documents, The facility has established appropriate guidelines pursuant to recommendations from the Illinois Department of Public Health and the Federal Centers for Disease Control. The policy addresses staff and visitor behavior and responsibilities to try to prevent the transmission of communicable disease Policy Interpretation and Implementation .2. To prevent the spread of respiratory germs within the facility .: a. Monitor employees prior to starting their shift for fever or respiratory symptoms b. Restrict residents with fever or acute respiratory symptoms to their room and place on droplet precautions. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated) 2. R3's Admission Record with a print date of 9/19/24 documents R3 was admitted to the facility on [DATE] with diagnoses that include retention of urine, acute cystitis without hematuria, and mild cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024
NAME OF PROVIDER OR SUPPLIER Integrity Hc of Herrin		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 North Park Avenue Herrin, IL 62948	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R3's MDS dated [DATE] documents a BIMS score of 02, which indicates a severe cognitive deficit. R3's current Care Plan documents a Focus area of (R3) is at risk for complications related to foley catheter placement related to Urinary Retention Date Initiated: 02/26/2024 This Focus area documents interventions that include, .2/21/24 Foley Cath care q (every) shift On 9/18/24 at 3:50 PM, V8 (Certified Nursing Assistant) provided catheter care to R3 per current standards of care. V8 changed gloves three times during catheter care and did not perform hand hygiene. When asked why she didn't perform hand hygiene with each glove change, V8 stated she forgot to do it. On 9/18/24 at 4:38 PM, V2 (Director of Nurses) stated she would expect hand hygiene to be performed between glove changes. The facility Handwashing/Hand Hygiene policy dated 8/2015 documents, This facility considers hand hygiene the primary means to prevent the spread of infection .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-microbial) and water for the following situations .m. after removing gloves .

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on observation, interview, and record review the facility failed to provide the required 80 square feet of floor space per resident for 8 of 8 (R6, R7, R14, R15, R17, R22, R28, and R32) residents reviewed for room size in the sample of 32. Findings include: On 09/19/24 at 7:23AM V1 (Administrator) accompanied by this surveyor measured R15 and R32's room with a measuring tape, the room measured 147 inches by 150 inches which equals 153.13 sq. square (sq) feet, which indicates 76.56 sq feet per person the room contained: 2 bed, 2 nightstands, 2 bedside tables, 1 oxygen concentrator, 2 wheelchairs, 1 portable oxygen tank, and a cabinet. On 09/19/24 at 7:24AM R15 who was alert to person, place, and time, stated he had no concerns with his room size. On 09/19/24 at 7:30AM V1 accompanied by this surveyor measured R17 and R14's room with a measuring tape, the room measured 142 inches x 150 inches which equals 145.83 square (sq) feet, which indicated 72. 92 sq feet per person the room contained: 2 beds, 1 chair, 2 nightstands, 1 miniature refrigerator, 2 bedside tables, 1 oxygen concentrator, 1 wheeled walker, and a cabinet. On 09/19/24 at 7:35AM R17 was sitting in her room laying down. R17 who was alert to person, place and time, stated she had no concerns with the size of her room. On 09/19/24 at 7:40AM V1 accompanied by this surveyor measured R22 and R28's room with a measuring tape, the room measured 142 inches x 150 inches which equals 145.83 square (sq) feet, which indicated 72. 92 sq feet per person the room contained: 3 beds, 3 nightstands, 2 bedside tables, 1 walker, 1 portable oxygen tank, 1 fan, 1 cabinet, 1 wheelchair, and 1 oxygen concentrator. On 09/19/24 at 7:44AM R22 was lying in bed. R22 who was alert to person, place, and time, stated that she had no concerns regarding her room size. R22 stated she has enough space in her room. On 09/19/24 at 7:47AM V1 accompanied by this surveyor measured R7 and R6's room with a measuring tape, the room measured 144 inches x 144 inches which equals 144 square (sq) feet, which indicates 72 square (sq) feet per person, the room contained: 2 beds, 3 nightstands,1 wheeled walker, 1 wheelchair, 3 bedside tables, 1 cabinet, and 1 miniature refrigerator. On 09/19/24 at 7:50AM R7 was observed sitting up in bed eating. R7 who was alert to person, place and time, stated that she has enough space in her room. R7 had no concerns regarding room size or space. On 09/19/24 at 10:15AM V1 stated all of the rooms at the facility are double occupancy except room number one and room [ROOM NUMBER] which is being used as offices. V1 stated rooms 3-12 on A hall were Medicaid certified and rooms 14-22 on B hall and 23-26 on C hall were Medicare/Medicaid certified. V1 stated that they have 27 skilled beds and 22 intermediate beds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Herrin	1900 North Park Avenue Herrin, IL 62948

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	The facility Bed Management Tool dated 09/16/24 documents R6, R7, R14, R15, R17, R22, R28, and R32 reside in the rooms observed and measured by V1. Review of 6 months of Resident Council meeting minutes indicated no concerns related to the size of the rooms.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 41610 Based on observation, interview, and record review the facility failed to provide a method to call for assistance while in the shower stall. This has the potential to affect all 32 residents residing at the facility. Findings include: On 09/18/24 at 11:20 AM the shower stall on the B hall does not contain a method to call for assistance from the shower stall, there is no access to a call light. On 09/18/24 at 11:30 AM the shower stall on the A hall does not contain a method to call for assistance from the shower stall, there is no access to a call light. On 09/19/24 at 12:02 PM V1 (Administrator) stated, the shower stalls should have a method to call for assistance that can be accessed from the floor if someone was in there, so another call box in the shower stall or a way to make the other call box string accessible from the shower. On 09/19/24 at 2:30 PM V1 stated, they do not have a policy regarding call light presence. The long term care facility application for Medicare and Medicaid dated 09/16/24 documents a census of 32 residents residing at the facility.