STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050997	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF MARION	**1301 EAST DEYOUNG , MARION, Illinois, 62959**

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S0000	Initial Comments Complaint Investigation 2556862/2570576	S0000		08/28/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 300.1210 c) 300.1210 d)1) 300.610. Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 300.1210. General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		08/28/2025

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

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S9999	Continued from page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure pain was treated for 1 of 1 (R3) resident reviewed for pain in the sample of 19. This failure resulted in R3 experiencing severe pain with no treatment for the first 24 hours of admission, resulting in a lack of sleep and emotional distress. Findings Include: R3's facility Admission Record, with a print date of 8/4/25, documents R3 was admitted to the facility on 7/30/25, with diagnoses that include sacroiliitis, surgical aftercare, diabetes, asthma, anemia, restless leg syndrome, Alzheimer's disease, and radiculopathy of lumbar region. R3's Baseline Care Plan, dated 7/30/25, documents R3 is alert with cognitive impairment. This Care Plan documents, "family states resident gets confused at times." Under Pain, this Care Plan documents R3 is in pain with no pain level documented. R3's Order Summary Report with Active Orders: "Percocet Oral Tablet 7.5-325 MG (milligrams)…Give 1 tablet by mouth every 6 hours as needed for pain. Start Date 07/30/2025." R3's Medication Administration Record, dated 7/1/25 to 7/31/25, documents a physician order to "Monitor and document pain level every shift. Start Date 07/30/2025 1800 (6:00 PM)." On 7/30/25 under Pain Level Night and 7/31/25 Pain Level Day, there is an 8, indicating R3 was experiencing pain at an 8 out of 10 level. This same MAR documents a physician order of, "Percocet Oral Tablet 7.5-325 MG (milligrams)…Give 1 tablet by mouth every 6 hours as needed for pain. Start Date 07/30/2025." There are no signatures indicating R3 received this medication on 7/30/25 or 7/31/25. R3's Progress Notes document the following.	S9999		

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S9999	Continued from page 2 7/30/25 10:12 AM, "report called from (name of regional hospital) …female with hx (history) of DM (diabetes mellitus), stroke, breast cancer, sleep apnea, Parkinsons, seizures, RLS (restless leg syndrome), liver failure, depression, GERD (gastroesophageal reflux disease), kidney stones. Resident c/o (complaints of) rt (right) leg pain, rx (prescription) for Percocet is being sent. Has lumbar laminectomy on 7/25 with a pain stimulator present." 7/30/25 2:30 PM, "Resident arrived via family personal car. Resident assisted into bed…. Resident is A/O (alert and oriented) x (times) 4 at this time, with family at bedside…" 7/30/25 4:47 PM, "Messaged MD (physician) for RX for Percocet as no scripts came with resident. Hospital stated they sent RX with her. Awaiting response." 7/31/25 8:58 AM, "Resident c/o pain 8/10. MD notified for PRN (as needed) pain pill Percocet 7.5/325 prn q (every) 6 (hours) signed script." 7/31/25 9:53 AM, "Tylenol offered for pian. Res (resident) refuses states it won't work. Awaiting response from MD for PRN Percocet script. 7/31/25 5:22 PM, "Pharmacy contacted for emergency release code for Percocet from (medication cabinet). Medication obtained and administered to patient." On 7/31/25 at 2:49 PM, R3 was laying in her bed covered with blankets. R3 stated she arrived at the facility yesterday morning and hasn't had any pain medication since her arrival. R3 stated she didn't get any medications until about an hour ago. R3 stated "last night was rough, no sleep, just sat here crying in the blanket." When asked why she didn't get her medications including her pain medication, R3 stated they didn't get the order from the doctor and couldn't get it from the pharmacy. On 8/6/25 at 10:37 AM, V23 (Certified Nursing Assistant/CNA) stated she provided care for R3 on her day of admission. V23 stated R3 was independent and did say she was in pain. V23 stated she told the nurse (V26/LPN-Licensed Practical Nurse) and they said the hospital didn't send a prescription for the pain medication. On 8/6/25 at 10:59 AM, V25 (CNA) stated she provided care to R3 on her day of admission, and she was hurting that day. When asked what they were doing to treat the	S9999		

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S9999	Continued from page 3 pain, V25 stated they were calling the pharmacy. On 8/6/25 at 10:23 AM, V26 (LPN/Licensed Practical Nurse) stated she was the nurse who admitted R3 to the facility. V26 stated she didn't remember what time R3 arrived at the facility. V26 stated she came in towards the end of her 6 am to 6 pm shift. V26 stated she complained of pain and V26 messaged the physician. V26 stated the hospital said they sent prescriptions for R3's pain medications, but R3 didn't have them. V26 stated she messaged R3's physician and he never responded. On 8/6/25 at 9:36 AM, V27 (RN/Registered Nurse) stated she was helping on R3's unit on her day of admission, 7/30/25. V27 stated she and V26 (LPN) were doing R3's admission together. V27 stated she left around 4:30 PM. V27 stated she did the charting and V26 put the medications in the system. V27 stated she could tell R3 was in pain, and she told V26 who was working on the orders. On 8/4/25 at 2:42 PM, V6 (Registered Nurse/RN) stated R3 admitted to the facility on 7/30/25, and her medications weren't available. V6 stated R3 was hurting, and it was an all-day event getting her pain medication. V6 stated towards the end of her shift (7/31/25), they were able to get in touch with R3's physician (V5), and got a prescription for her Percocet. V6 stated she had another nurse message V5 on their message app first thing that morning, since she didn't have access to the app yet. V6 stated V2 (Director of Nurses) got involved with it and V5 gave them the prescription they needed. When asked if there was a reason she didn't call V5 when he didn't respond to their messages, V6 stated it just "went over my head." V6 stated she did offer R3 Tylenol, and she refused it. V6 stated they have issues with the pharmacy not always sending the medications. V6 stated if they don't get a medication from the pharmacy, they are supposed to get it out of the (medication cabinet) if they can and/or notify the physician. On 8/4/25 at 3:16 PM, V9 (Licensed Practical Nurse/LPN) stated he did a comprehensive pain assessment on R3, and she had pain in her femur that shoots down her right leg that can be a 7 out of 10 at times. V9 stated he gave R3 pain medications as needed all day on the days he provided care to R3, and he believed he gave her Tylenol also for breakthrough pain. V9 stated he assisted her with turning and repositioning as well. V9 stated if they don't have medications to administer to residents who newly admit, he calls the pharmacy, contacts the physician, and gets them from the	S9999		

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S9999	Continued from page 4 (medication cabinet). V9 stated if he can't get them from the (medication cabinet) he calls the pharmacy and has them send the order to a local pharmacy so they can get a supply until their pharmacy can deliver them. On 8/4/25 at 4:02 PM, V10 (CNA/Certified Nursing Assistant) stated she assisted R3 with a shower on 7/31/25 or 8/1/25. V10 stated R3 appeared slightly confused and worried. V10 stated R3 complained of lower back pain when they transferred her. On 8/6/25 at 1:11 PM, V2 (Director of Nurses) stated she was aware R3 didn't get her pain medication until 7/31/25. V2 stated when R3 was admitted, the nurse reached out to V5 via the messaging app and didn't hear a response through the night. V2 stated after this surveyor spoke with her and V1 (Administrator) about the situation on the afternoon of 7/31/25, she reached out to V5, and he told her he had sent the order to the pharmacy at 9:30 AM on 7/31/25. V2 stated she called the pharmacy and got the emergency release code and pulled the prescription out of the (medication cabinet). V2 stated the nurse working did not realize she could pull the medications from the (medication cabinet) and they have educated her and all of the other nurses on what to do if they don't have the prescription and/or the medications are not delivered from the pharmacy. On 7/31/25 at 4:20 PM, V1 (Administrator) stated R3 came to them with no hard prescription for her pain medications and they had contacted R3's physician the morning of 7/31/25 and hadn't heard anything back at this time. When asked what the normal procedure would be if a resident didn't have the medications they needed, V1 stated they would get the order from the attending physician and/or medical director, contact the pharmacy, and it would be delivered. When asked if they had done that with R3's medications, V1 stated they had contacted the physician the morning of 7/31/25. When asked what the next step would be to ensure R3's pain was treated, V1 stated she "guessed" they would send R3 to the emergency room. V1 stated they did offer R3 Tylenol for the pain, and she refused it. On 8/5/25 at 2:37 PM, V5 (Physician) stated he got a text late afternoon on 7/30/25 related to R3 not having pain medication. V5 stated the actual prescription wasn't sent to the pharmacy until 7/31/25 at 9:30 AM, and then it went into a prior authorization bin, and that may have delayed it. V5 stated he wasn't sure how long it sat in the bin. V5 stated having the pharmacy call him for emergency medication is the safest way to	S9999		

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S9999	Continued from page 5 get them. V5 stated he got messages on 7/30/25 at 4:40 PM that she admitted and needed scripts for the pain medication and on 7/31/25 at 8:57 AM he received a message R3 was in severe pain. V5 stated then they called him sometime that afternoon. The facility Pain Management Policy, dated 2022, documents, “Purpose: To facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. General Guidelines: The facility will achieve these goals through: Promptly and accurately assessing and managing pain to the greatest extent possible…. Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. Communication with the physician will ensure an appropriate individualized pain management plan….” (B)	S9999		