

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0051011		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/03/2026	
NAME OF PROVIDER OR SUPPLIER INTEGRITY HC OF ANNA				STREET ADDRESS, CITY, STATE, ZIP CODE 315 SOUTH BRADY MILL ROAD , ANNA, Illinois, 62906			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			03/09/2026	
	Facility Reported Incident of February 13, 2026/2786110						
S9999	Final Observations		S9999			03/09/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210d)6)						
	Section 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.						
	Section 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.						
	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:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidence by: Based on interview and record review the facility failed to ensure the safety of 1 of 3 (R5) residents reviewed for accidents in the sample of 20. This failure resulted in R5 falling out of his wheelchair when the van made a sudden stop, resulting in R5 sustaining fractured ribs and clavicle. This past non-compliance occurred between 2/13/26 and 2/16/26. Findings include: R5's Admission Record with a print date of 2/26/26 documents R5 was admitted to the facility on 6/27/25 with diagnoses that include history of myocardial infarction, heart failure, hypertension, and atrial fibrillation. R5's Minimum Data Set dated 1/1/26 documents R5 has a Brief Interview Mental Status Report score of 13, indicating R5 is cognitively intact. R5's current Care Plan documents a Focus area of, "ADLs: (R5) has limited physical mobility r/t (related to) COPD (chronic obstructive pulmonary disease) and being on oxygen. Date Initiated: 01/14/2026..." This same Focus area includes the Intervention of, "Ambulation: (R5) requires a wheelchair to ambulate the facility. Date Initiated: 01/14/2026." R5's Fall report dated 2/13/26 documents, "Received a call from transport driver stating that while on transport a deer ran in front of the van. The brakes were applied abruptly, and resident came out of wheelchair striking his head on the floor.... Resident taken to (initials of local hospital) for evaluation. Upon return from hospital no injuries were noted...RCA (root cause analysis) malfunction of seatbelt per staff. Immediate Intervention: Resident taken to (initials of hospital) for eval (evaluation)...van taken out of service, re-education of staff with return demonstration...Notes: R (right) clavicle fx (fracture), rib fx, initially cleared at (name of hospital) ER			S9999			

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S9999	Continued from page 2 (emergency room), after return to building had increased pain, which was addressed, new xray indicated fxs on 2/16/26." R5's Progress Notes document the following, 2/13/26 2:45 PM, "Received call from staff stating that a deer ran in front of the facility van, brakes were applied and (R5) was noted in the floor of the van. I instructed the staff member to take resident to (name of hospital) for evaluation." 2/13/26 6:15 PM, "(R5) back in facility with a diagnosis of shoulder strain. No new orders received." 2/15/26 2:50 PM, "(R5) returned a call to (name of nurse) and ordered lidocaine patch and ice to the effected area. Lidocaine patch and ice applied." 2/16/26 11:00, "Resident continues on monitoring checks post fall on 2/13. WNL. (within normal limits). Current vital signs are WNL...Resident complaining of pain to right ribcage. (name of physician) ordered lidocaine patch yesterday per orders. This nurse reached out about obtaining x-ray, awaiting response..." 2/16/26 11:24 AM, "(name of physician) agrees with order of 2 view x-ray to right ribcage..." 2/16/25 3:16 PM, "Received results from Biotech via fax. Results show: acute non-displaced right lateral 10th rib fracture and acute distal clavicle fracture... DON (Director of Nurses and administrator aware." 2/16/26 4:32 PM, "...orders to send resident to ER (emergency room). 911 contacted...." 2/16/26 6:43 PM, "Resident arrived back to facility with order for hydrocodone 5-325 mg (milligrams) Q (every) 6h (hours) PRN (as needed) for pain and to follow up with orthopedics. Sling in place to right arm." R5's hospital records dated 2/16/26 documents a discharge summary that indicates R5 was discharged with diagnoses of fractures, including a fractured clavicle. On 2/26/26 at 9:16 AM, R5 stated he was in the van going to an appointment and the driver made a quick stop. R5 stated he hit the dashboard, and the wheelchair landed on top of him. R5 stated he went to the emergency room, and they did x-rays and sent him home. R5 stated he didn't remember if he was buckled in or if the wheelchair was buckled but it must not have			S9999			

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S9999	Continued from page 3 been for the wheelchair to have ended up on top of him. On 2/26/26 at 10:22 AM, V11 (CNA/Certified Nursing Assistant) stated she was driving the van on 2/13/26 when R5 fell. V11 stated there are four clamps that lock the wheelchair in place and then the seatbelt on the resident. V11 stated when the van stopped, R5 was sitting on the floor and as she was assisting him up the wheelchair fell over because R5 was too heavy for her to lift by herself. V11 stated she did eventually get him into his chair. V11 stated she had buckled R5 and the chair in prior to starting the trip. On 2/26/26 at 10:46 AM, V12 (CNA) stated she knew R5 wasn't buckled in properly on the day the incident occurred (2/13/26). V12 stated R5 went flying and ended up with a broken clavicle. When asked how she knew R5 wasn't buckled in, V12 stated, R5 told her he wasn't buckled in. V12 stated she didn't know when R5 told her that. On 2/25/26 at 9:20 AM, V1 (Administrator) stated on the day the incident occurred, the driver stopped suddenly to keep from hitting a deer. V1 stated R5 was in the wheelchair with a seat belt on but it came unlatched and R5 fell. V1 stated they took R5 to the emergency room and they said he had a shoulder strain. V1 stated R5 continued to complain of pain so they notified the physician and got a pain patch ordered. V1 stated R5 continued to complain of pain so they got new x-rays and found a fractured clavicle and ribs. V1 stated after the incident they took the van out of commission until it could be checked by mechanics. V1 stated the seat belt appeared to be functioning properly. V1 stated the driver no longer works at the facility. On 2/26/26 at 1:48 PM, V1 stated V12 does work for the facility but was suspended pending the outcome of the investigation. The Self-Identified Quality Assurance Plan of Correction dated 2/13/26 documents, "...Problem Identified: Resident had a fall in facility transportation van. 1. Corrective Action(s)...(R5) will be taken to ER (emergency room) for evaluation. 2.... All residents transported by facility van have the potential to be affected by the alleged deficient practice.... Facility immediately re-educated staff on proper securing of residents in seatbelt of transportation van. All van drivers' re-education initiated with return demonstration on proper seatbelt application in the van. Facility immediately initiated an incident investigation. Van removed from service for seatbelt safety check to be completed. Facility completed incident investigation and placed safety			S9999			

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S9999	Continued from page 4 intervention with updated care plan. ADMIN (administrator/V1), DON (Director of Nurses/V2 and/or designees will do random observations of at least one staff member securing a wheelchair in transportation van a minimum of 5 times per week for 4 weeks. ADMIN, DON and/or designee will do random education checks to ensure staff is knowledgeable of proper wheelchair securement in transportation van minimum of 5 times per week for 4 weeks. Results of the observations will be discussed in the Quarterly QA (quality assurance) Meeting times 2 with education needs discussed as needed by the Facility Administrator/DON and/or designee. According the Survey Plan of Correction Tool training was completed on 2/16/26. The facility undated Drive Safe Program documents under 2. Transporting Residents and Employees, "...Driver of vehicle is responsible to make sure all passengers are securely seated and use their seat belts. No employee is authorized to ride or work from the bed or rear of a vehicle while it is in motion..." "B"			S9999			