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 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF ANNA	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 Complaint Survey: 2554977/IL193751, 2554873/IL193414 & FRI of 5/22/2025/IL193328	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210b) 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. These Requirements were NOT MET as evidenced by:	S9999		

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

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 06/09/2025

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S9999	Continued from page 1 Based on interview, observation, and record review the facility failed to ensure residents were treated with dignity by not providing incontinence products for 4 of 6 residents (R3, R5, R6 and R7) reviewed for resident rights in a sample of 16. This failure resulted in R3, R5, and R7 feeling embarrassed after incontinence episodes. The findings include: 1. R3's Admission record dated 06/06/25, documents an admission date of 03/07/22 to the facility with diagnoses in part of pressure ulcer of sacral region stage 4, pressure ulcer of other site stage 3, type 2 diabetes mellitus with foot ulcer, and non-pressure chronic ulcer of buttock with unspecified severity. R3's Minimum Data Set (MDS) dated 04/08/25 documents in Section C a Brief Interview for Mental Status (BIMS) score of 10 which indicates moderately impaired cognition. Section GG documents that R3 is dependent for toileting. Section H documents R3 is occasionally incontinent of urine and always incontinent of bowel. R3's Care Plan documents a focus area of R3 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) multiple health issues including cerebral palsy, DM (Diabetes Mellitus), IBS (Irritable Bowel Syndrome) and vertigo. R3 utilizes a wheelchair for locomotion in which she can propel herself very short distance with a revision date of 08/02/21. On 06/03/25 at 9:20AM, R3 stated that they don't put incontinent briefs on her at nighttime anymore. R3 stated that she would prefer to wear an incontinent brief at night, because she doesn't like wetting herself on a bed pad. R3 stated that she feels embarrassed and yucky at nighttime when she doesn't have an incontinent brief on. R3 said that she has asked staff several times for them to put an incontinent brief on her at nighttime, but they refuse to put one on her. R3 said that she doesn't know if they don't have any incontinent briefs to put on her or if they just don't want her to wear one at night.	S9999		

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S9999	Continued from page 2 2. R5's Admission record, dated 06/06/25, documents an admission date of 01/26/25 with diagnoses in part of chronic obstructive pulmonary disease, type 2 diabetes mellitus, obesity, non-pressure chronic ulcers of other part of right foot with fat layer exposed, lymphedema, and chronic kidney disease. R5's MDS dated 04/29/25 documents in Section C a BIMS score of 15 which indicates R5 is cognitively intact. Section GG documents toileting as substantial/maximal assistance. Section H documents that R5 is frequently incontinent of bladder and bowel. R5's Care Plan (with a revision date of 5/7/25) documents focus areas of with a revision date of R5 is at risk for falls and R5 is at risk for pressure injury. On 06/04/25 at 3:27PM, R5 stated he does have a problem with running out of his size incontinence briefs. R5 said they also want him to go without incontinent briefs at nighttime. R5 said that the facility doesn't order enough briefs and sometimes he has had to use a smaller brief. R5 said that they run out of his size incontinence briefs often. R5 said that he has even went without a brief at times, because they didn't have any for him to wear. R5 said that he doesn't like his clothes getting wet or peeing on himself. R5 said that he also doesn't like not having one at nighttime. R5 said he wakes up soaking wet and his bed is sometimes wet as well. R5 said that it is embarrassing to have your clothes all wet in urine and your bed soaked. 3. R7's Admission record dated 06/06/25, documents an admission date of 05/20/25 to the facility with diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, type 2 diabetes mellitus, presence if cardiac pacemaker, and old myocardial infarction. R7's MDS dated 05/27/25 documents in Section C a BIMS score of 13 which indicates R7 is cognitively intact. Section GG documents that R7 requires set-up and supervision with toileting. Section H documents R7 is occasionally incontinent of bladder and continent of bowel. R7's Care Plan (revision date of 5/20/25) documents a	S9999		

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S9999	Continued from page 3 focus area of R7 has an ADL deficit related to needing assistance with ADL's related to dx (diagnosis) of hemiplegia and hemiparesis following CVA affecting the left non-dominant side. R7 is able to feed himself with set-up assistance only. R7 requires weight bearing assistance with most ADL's. R7 uses a wheelchair for locomotion and is able to propel himself. On 06/05/25 at 10:08AM, R7 stated that there are days he has had to go without an incontinent brief because the facility doesn't have any. R7 said that he does have a couple of staff members that will hide some of his size incontinent brief to make sure he has some for the daytime. R7 said that he has gone days without any incontinent briefs, and he didn't like it. R7 said that it embarrassed him to be wetting himself. R7 said that they also make him go all night without wearing an incontinent brief now. R7 said that he asked if he could wear one during the night, but that staff told him they don't use them at nighttime now. 4. R6's Admission record dated 06/06/25, documents an admission date of 04/11/23 to the facility with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, transient cerebral ischemic attack, retention of urine, aphasia, and chronic kidney disease. R6's MDS dated 04/15/25 documents in Section C a BIMS score of 03 which indicates severe cognitive impairment. Section GG documents that R6 is dependent for toileting. Section H documents R6 is frequently incontinent of bladder and bowel. R6's Care Plan has a focus area of R6 has an ADL (Activities of Daily Living) self-care performance deficit r/t hemiparesis to the right side following CVA (Cerebral Vascular Accident). R6 has weakness to the RUE (Right Upper Extremities) and RLE (Right Lower Extremities) which is dominant. On 06/03/25 at 1:54PM, V19 (Family Member) stated that sometimes the facility runs out of incontinent briefs. V19 said that they stopped putting incontinent briefs on R6 at nighttime. V19 said that now R6 must sit and lay in urine or stool until someone cleans him up. V19 said when R6 use to wear the incontinent briefs at nighttime when he urinated the incontinent brief would pull the urine away from his skin, now he just lays in	S9999		

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S9999	Continued from page 4 it. On 06/03/25 at 11:08AM, V8 (Certified Nurse Assistant/CNA) stated that the facility stopped using incontinent briefs at nighttime on residents. V8 said that the facility had ran out of incontinent briefs and that they have had to let the resident go without an incontinent brief during the day and at nighttime. V8 said that residents will wet themselves, and they will just clean up the resident and change them. On 06/03/25 at 12:51PM, V1 (Administrator) stated that the reason the facility runs out of incontinent briefs is because staff isn't putting stuff on the list for her to order. V1 said that they stopped putting incontinent briefs on residents at nighttime, so the residents have time to air out. On 06/03/25 at 1:15PM, V9 (CNA) stated that they ran out of incontinent briefs for the residents just last week. V9 said that they have went several days with some residents not having any incontinent briefs. V9 said that they just check and change the residents often and try to make sure they stay dry. On 06/03/25 at 12:06PM, V10 (CNA) stated that the facility has ran out of incontinent briefs at times and they had to put resident in clothes without an incontinent brief on. V10 said that they checked and changed the resident to make sure they did not have an accident and if they had an accident then they would clean the resident up and change their clothes. V10 said they ran out of the larger incontinent sizes the most. V10 said that V1 would have some supplies in her office and that they had to ask for the supplies for the residents. On 06/03/25 at 3:02PM, observed storage room on B hall which had 2 boxes of gloves and at least 24 x-large incontinent briefs and 22 medium incontinent briefs. There were no other sizes of briefs noted. On 06/03/25 at 3:10PM, observed storage room on A hall which had 6 boxes of gloves and 30 x-large incontinent briefs and 34 medium briefs. There were no other sizes of briefs noted.	S9999		

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S9999	Continued from page 5 On 06/03/25 at 3:12PM, observed the shed outside which is used to store extra supplies. There were 2 boxes of Medium incontinent briefs and 1 x-large incontinent brief box. On 06/04/25 at 1:46PM, V13 (CNA) stated that they have run out of incontinent briefs at times and they had to call V1 to get them some incontinent briefs for residents. On 06/04/25 at 2:05PM, V1 stated that she provides incontinent briefs for all residents and all sizes. V1 said that she doesn't order many incontinent briefs. V1 stated that she did have an order in for some incontinent briefs but the order did not come in today so she had to get an order from the local store until her shipment comes in. On 06/04/25 at 3:00PM, V1 stated that her supplies from the local store arrived, but she still did not receive her supplies from the company she normally orders from. On 06/04/25 at 2:15PM, V14 (CNA) stated that she has been told by V1 not to put incontinent briefs on residents at nighttime unless they ask to have one on. On 06/05/25 at 7:19AM, V6 (CNA supervisor) stated they do have a problem with running out of incontinent briefs at times. V6 said that she will let V1 know when they run out of something and V1 will go get what she needs. V6 said that resident do not wear incontinent briefs at nighttime now unless they request to wear one then we put one on them. V6 said that they use to have a problem with running out of 2 x large incontinent briefs and larger. On 06/05/25 at 7:30AM, V1 stated that she does not like to use depends at nighttime because she feels like it increases skin breakdown on residents. V1 said that she feels like the residents need time to dry out. V1 said that a doctor did not give her an order to not put an incontinent brief on the residents at nighttime. V1 said that if a resident is alert and requests to wear an incontinent brief at nighttime they should be allowed to wear one. V1 stated she did not call and see what the families of the resident who are not alert would prefer if they would like their family member to wear a brief at nighttime or not. V1 said that she did	S9999		

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S9999	Continued from page 6 find in the contract that it says the facility is to provide incontinent care and supplies. V1 said that she knows that it doesn't have to be a specific brand, but it does have to be the appropriate size. On 06/05/25 at 7:44AM, observed storage room on B hall which had 1 box of gloves and 15 x-large incontinent briefs and 10 small incontinent briefs. On 06/05/25 at 7:46AM, observed storage room on A hall which had 25 x-large incontinent briefs and 20 medium incontinent briefs. On 06/06/25 at 10:46AM, V17 (Business Office Manager) stated that the facility is to provide incontinent briefs to all resident regardless of their payor source. On 06/06/25 at 2:00PM, V1 stated that the facility did not have a policy on incontinent care or incontinent supplies. The facility document titled "Resident Grievance/Concern Follow-up Form" dated 04/02/25 and completed by the Resident Council documents under describe the nature of the grievance/concern documents get bigger size pull-ups (incontinent briefs). The sections documenting recommendations and efforts made by the facility to resolve the concern is left blank. Another "Resident Grievance/Concern Follow-up Form" dated 05/06/25 documents "still running out of bigger size pull-ups." Under the section that describes what efforts were made by the facility to resolve the concern it documents "see attached." The facility document titled " Resident Council Memorandum" dated 04/02/25 documents an issue of "bigger sized pull-ups" and a response of "staff educated to use appropriate size and update order board when stock getting low" signed by V1. Under "Follow up in Resident Council" with a date of 05/06/25 documents "residents feel that they are still running out." The facility document titled " Resident Council Memorandum" dated 05/06/25 documents an issue of "running out of pull-ups in bigger sizes" and a response of "CNA meeting in progress this wk (week)	S9999		

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S9999	Continued from page 7 discussing pull-ups and depends (incontinent briefs) educated to use appropriate size and to not place on residents in bed" signed by V1. The facility Resident Admission Packet with a revision date of 12/24 documents under Statement of Resident Rights under section I. Services included in Medicare and Medicaid payment documents "During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services. (E) routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfesting soap or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry." The facility policy titled "Dignity Policy" with a revision date of 08/2009 documents the policy statement as "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality." B 2 of 2 Licensure Violations 300.1210b) 300.1210c) 300.1210d)6 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	S9999		

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S9999	Continued from page 8 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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 Requirements were NOT MET as evidenced by: Based on interview and record review the facility failed to implement interventions to prevent future falls for 1 of 3 (R2) residents reviewed for falls in a sample of 16. This failure resulted in R2 falling and sustaining a laceration on his face requiring sutures. Findings include: R2's Admission Record documents an initial admission date of 12/10/20 and a discharge date of 5/23/25 with diagnoses including in part Alzheimer's disease, legal blindness, abnormalities of gait and mobility, and lack of coordination. R2's Minimum Data Set (MDS) dated 4/8/25 documents a Brief Interview for Mental Status (BIMS) score of 0 indicating that R2 is rarely/never understood. R2's most recent Care Plan documents a focus area of Falls: R2 is at risk for falls related to severely impaired mobility and very poor safety awareness with an initiation date of 12/16/20. Interventions documented include R2 is to be promptly laid down after all meals to reduce sleeping in his wheelchair, thus reducing risk of fall dated 2/6/25, staff educated to recline back of high back wheelchair and to ensure it	S9999		

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S9999	Continued from page 9 is pushed under the table and locked for safety dated 3/31/25, and wheelchair to be tilted back in reclining position for safety dated 6/21/21. R2's Fall Risk Assessment dated 2/7/25 documents a score of 10 with a score of 10 or greater indicating that the resident is at a high risk for falls. R2's Fall Risk Assessment dated 4/7/25 documents a score of 10 and the assessment dated 5/22/25 documents a score of 15. R2's Nurse's Note dated 2/6/25 at 9:30 AM documents "this nurse was at med (medicine) cart, alerted by CNA (Certified Nursing Assistant) to look further down the hallway where (R2) was noted to be laying in the floor on R (Right) side beside wheelchair. Fall was not witnessed. Head to toe assessment completed. No evidence of pain/discomfort noted at this time. No skin injury or redness noted. No physical injury or deformities noted. Neuro (Neurological) at baseline for (R2) at this time, neuro checks initiated. vitals BP (Blood Pressure) 127/75, HR (Heart Rate) 79, RR (Respiratory Rate) 16, temp (Temperature) 97.8, O2 sat (Saturation) 92%. (R2) assisted back to w/c (Wheelchair) x3 staff. immediate intervention - CNA's educated to lay resident down promptly after all meals, verbalized understanding. RCA (Root Cause Analysis): (R2) post meal sleeping in w/c, fell forward onto floor." R2's Nurse's Note dated 3/31/2025 at 5:30 PM documents "Nurse was notified that (R2) was laying in the floor in the dining room and had fallen out of his wheelchair. (R2) was observed laying on his right side. (R2) has a laceration to right eyebrow measuring approximately 2cm (centimeters) x 0.4cm and can't measure depth d/t (Due To) hair present. Laceration cleansed with NS (Normal Saline) and pressure applied to stop bleeding. (R2) assisted back into wheelchair with staff x2. (R2) unable to express how fall occurred. Neurological exam performed and within normal limits. Vital signs obtained: 97.4, 69 pulse, 18 respirations, 121/87. ROM (Range of Motion) x4 without s/s (signs/symptoms) of pain. No shortening or deformity of extremities. Environment was dry floor, adequate lighting, non-skid socks on. Physician and POA (Power of Attorney) notified. Resident sent to (Local Hospital) ER for eval (evaluation) & treat." R2's Nurse's Note dated 3/31/25 at 10:51 AM documents	S9999		

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S9999	Continued from page 10 "(R2) returned back to facility at 2132 (9:32 PM) via facility van. 5 stitches to the R (Right) eyebrow, remove in 10 days. Monitor for s/s (Signs/Symptoms) of infection. MD (Physician) notified. Attempted to call Resp (responsible) party but no answer. Left a voicemail for her to call us back. (R2) in bed at this time. Resp (respirations) even and unlabored. Bed in lowest position. Floor mat at bedside. VS (Vital Signs) wnl (within normal limits). No SOB (Shortness of Breath). MA (Moves All) extremities. PERL (Pupils Equal and Reactive to Light). Call light within reach. CT (Computed Tomography scan) of head and spine done with no findings." R2's Nurse's Note dated 5/22/25 at 4:34 PM documents "CNA called for this nurse to entrance hallway. (R2) noted to be laying on R side in fetal position, DON (Director of Nursing) sitting at head, blood noted to be coming from head. Applied pressure w/ (With) guaze [SIC]. Previous laceration site reopened at R (Right) eyebrow, laceration noted tobridge [SIC] of nose, nose noted to be slightly deviated to the R. Pressure dressing about [SIC] to laceration at eyebrow. (R2) nonverbal and unable to vocalize what happened or if he was in pain. CNA states resident refused to extend legs and remained in fetal position when got out of bed for dinner, and en route to dining room, (R2) leaned forward and fell out of w/c (wheelchair). EMS (Emergency Medical Services) called for transport to (Local Hospital) ER for eval (Evaluation) and treatment. EMS place c-collar upon arrival. (R2) assisted to stretcher x4 staff. MD notified. attempted to notify POA (Power of Attorney), no answer at this time, voicemail left to return phone call to facility. RCA (Root Cause Analysis): (R2) in fetal position in w/c, leaned forward, and fell. Immediate intervention: resident sent to (Local Hospital) ER for eval and treatment, (R2) will use geri chair (reclining chair with wheels) upon return as he is unable to self-propel." R2's Nurse's Note dated 5/22/25 at 10:16 PM documents "(R2) returned back to facility via Ambulance from (Local Hospital) at 2208 (10:08 PM). (R2) has 6 sutures to the R eyebrow and a laceration to the bridge of the nose. CT of the facial bones, head and spine all came back as no acute fx (fracture). (R2) vs wnl and stable at this time. Resp even and unlabored. POA notified. MD notified. Sutures to be removes [SIC] in 1 week on 5/29. Keep area clean and monitor for any s/s (signs and symptoms) of infection u/h (until healed). Bed in lowest position. Floor mat at bedside at this time.	S9999		

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 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF ANNA	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
S9999	Continued from page 11 Call light within reach." R2's Nurse's Note dated 5/23/25 at 1:21 AM documents "Alert with baseline confusion. PERL. Moves all extremities at this time. Hand grasp equal. Pain expressed when site to R eyebrow or nose is touched." R2's Nurse's Note dated 5/27/25 at 11:26 AM documents "On 5/22/25 at approximately 1630 (4:30 PM) (R2) had a fall from wheelchair. (R2) was assessed for injury, ROM (Range of Motion) and pain. (R2) was noted to have a laceration to the R eyebrow. MD, and POA notified. MD order to send resident to ER. (R2) returned with 6 sutures to R eyebrow area and per CT possible anterior mandible fracture vs. variant anatomy, no findings of acute facial bone fracture. Investigation was immediately initiated. During the investigation it was found that while the resident was being assisted to dining room, he put his foot down and fell forward. Resident is not educatable related to BIM of 99, upon his return the immediate intervention is assist to geri recliner (reclining chair on wheels) as he keeps his positioning in knees up/fetal position and occassionally [SIC] puts feet down, he also leans forward frequently, he is unable to propel self so thichair [SIC] would not be a restraint." R2's hospital records dated 5/22/25 at 5:19 PM documents under Physical Exam, Skin: Laceration to right forehead, eyebrow, and bridge of nose. In the same document under Laceration Repair, it documents Face location: right eyebrow, Length: 2.3 centimeters, and Depth: 1 millimeter. Layers/structure repaired: Deep dermal/superficial fascia number of sutures: 2 and Skin repair number of sutures: 4. In the same document it documents under Medical Decision Making: laceration repaired with suture to face and adhesive skin over bridge of nose without complication. Final Impression: 1. Laceration of multiple sites of face, 2. Contusion of face due to delivery. On 6/5/25 at 10:45 AM, V21 (CNA) stated she was pushing R2 on 5/22/25 when he fell forward out of his wheelchair. V21 stated she was pushing him to dinner and all his weight shifted forward then he fell forward out of the wheelchair, and she doesn't remember if he had foot pedals on the wheelchair. V21 stated the back of the reclining wheelchair was straight up and not reclined when she was pushing him when the fall occurred.	S9999		

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 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF ANNA	315 SOUTH BRADY MILL ROAD , ANNA, Illinois, 62906

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S9999	Continued from page 12 On 6/6/25 at 7:44 AM, V1 (Administrator) stated R2 did not have foot pedals on his wheelchair, and he did not propel himself around in his wheelchair. V1 stated he would keep his feet pulled up under his chair and she didn't think foot pedals would be appropriate. On 6/6/25 at 7:46 AM, V2 (Assistant Director of Nursing) stated R2 did not propel himself in his wheelchair and she didn't think foot pedals on his wheelchair would work because he pulls his feet under the chair. On 6/6/25 at 9:30 AM, V4 (Rehab Director/Physical Therapy Assistant) stated R2 had a high back wheelchair that reclined, and they added a neck support to it to help with posture. V4 stated when he was eating the chair should be sitting straight up and other times it should be reclined for comfort and safety. V4 stated he didn't have the body strength to sit straight up on his own, his hip tendons were getting tight so that made him lean forward. V4 stated he was also getting contractures in his hips and knees making him lean forward and making his feet go back under the chair. V4 stated the wheelchair should be reclined for safety and comfort unless eating. A facility policy titled Fall Management dated 2019 documents under Standards: 3. Safety interventions will be implemented for each resident identified at risk using a standard protocol, 4. The admitting nurse and assigned CNA and/or designees are responsible for initiating safety precautions at the time of admission. Facility staff are responsible for assuring ongoing precautions are put in place and consistently maintained. B	S9999		