STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by the Illinois Department of Public Health on 10/23/2020. The facility was found to be in compliance with 42 CFR §483.73 related E-0024 (b)(6).	E 000		

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

Electronically Signed | 11/17/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 000	INITIAL COMMENTS Complaint Investigation 2058211/IL127809 - No Deficiency 2058243/IL127841 A Focused Infection Control Survey/COVID-19 Focused Survey was conducted by the Illinois Department of Public Health on October 23, 2020. Survey Census: 29	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		11/16/20

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

Electronically Signed | 11/17/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the primary care physician and/or resident representative of a change in condition for 5 (R1, R3-R6) of 6 residents reviewed for change in condition in a sample of 11. Findings include: On 10/15/20 at 3:45 PM, V14 (Master's in Physician's Assistant Studies-Physician's Assistant Certified/ MPAS-PAC) stated, "We (V14 and V11/Registered Nurse/RN) came into the facility again on 10/08/20 for rounds, were told all	F 580	1. The corrective action for the alleged deficient practice has been achieved by the following: A. Licensed Nursing staff were in serviced by Administrator on Notification of Doctor and family for change of condition or injury on 16NOV2020. (Attachment A) 2. All residents have the potential to be effected by the alleged deficient practice. However, due to the implementation of 1 A, the alleged practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 580	Continued From page 2 residents were positive for Covid-19, and we learned this when walked into the facility. The number had jumped since our last visit on 10/05/20." V14 stated she called V19 (Medical Director/Primary Care Physician/PCP) and learned he had not been notified of this either. V14 stated, "Staff have all my phone numbers and I've told them all that if I don't answer, text me, because I can always get texts even if I don't have a good phone signal. They have not done this, and facility communication had not been good." R1 and R3-R6's record contains a "Report of Lab Result" form confirming testing a positive result for Covid-19 received on 10/04/20 and reported to the facility on 10/05/20. When asked for confirmation that notifications had been given to V14 and V19 regarding R1 and R3-R6's positive Covid-19 test result, as well as confirmation the facility returned V25 (Family Member) and V29's (Family Member/Power of Attorney/POA) phone calls regarding R3, V1 (Administrator) was unable to provide this documentation. V1 added that much of this occurred during a period when the facility was using float pool staff and they did not put things in the charts where they were supposed to be. On 10/21/20 at 2:25 PM, V25 (Family Member) stated R3 returned to the facility via ambulance on the morning of 10/15/20 after being in the hospital. V25 stated she and V29 (Family Member/Power of Attorney/POA) called the facility multiple times that day in an attempt to get an update on R3's condition. V25 stated they had been calling the facility for over 6 hours, but their calls were not returned until that afternoon after	F 580	3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: A. All newly hired licensed staff will be in serviced regarding the facility□s policy and procedure for Notification of Change in Resident Condition or Status. B. DON or designee will monitor to ensure that all parties are notified in timely manner for change of condition or injury. 4. The following Quality Assurance programs have been implemented to ensure continued compliance. A. The QA team will monitor through the daily internal QA process. B. The Administrator will ensure compliance through her routine Quality Assurance rounds .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 580	Continued From page 3 R3 had passed away. V25 stated if they would have known R3 was that bad, they could have come to the facility and at least been able to see her through the window to be with her. R3's record documents the following nursing notes, in part, on 10/15/20: 10:00 AM "...transported by ambulance from local (name of hospital). Skin cold and clammy, dark mottling of BLE (bilateral lower extremities). Unresponsive to stimuli. 02 (oxygen) at 2L (liters) NC (nasal cannula). Pulse weak and irregular with HR (heart rate) of 154. Comfort care ordered. T & P (turn and position) q (every) 2 hours per orders. Will continue to monitor..."; 2:00 PM - "...89% with 02 at 3L/NC. Continues to be unresponsive. Resp (respirations) labored with use of accessory muscles. Comfort care continues." 4:46 PM - "Noted with no pulse and no respirations." 4:48 PM - "V29 notified that res (resident) passed away." On 10/23/20 at 10:04 AM, V19 (Medical Director/Primary Care Physician/PCP) stated V14 is his "right hand" and has been the one in the facility. V19 confirmed facility communication has not been good, temporary staff or not, and he learned that all residents were positive of Covid-19 from his PA.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		11/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 684	Continued From page 4 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow physician's orders, implement interventions. and provide comfort care as ordered for 3 (R2, R3, R5) of 3 residents reviewed for physician's orders in a sample of 18. Findings include: 1. R2's medical record contains the following Covid-19 Assessments documenting R2's temperatures, in part: 10/02/20 at 8:00 AM - 99.1; 10/09/20 at 8:00 AM - 100.2; 10/09/20 at noon - 99.3; 10/11/20 at 8:00 PM - 99.1; 10/14/20 at midnight - 99.5; 10/14/20 at 8:00 AM - 99.1; 10/16/20 at 8:00 PM - 99.5. R2's October POS (Physician's Order Sheet) documents an order for Acetaminophen 325 mg (milligram) tablet, take 2 tablets (650 mg) by mouth every 6 hours as needed for pain/fever; Acetaminophen suppository 650 mg, insert 1 suppository rectally every 4 hours as needed temp (temperature) greater than 99 degrees. R2's October MAR (Medication Administration Record) documents the same orders, with an updated order date of 10/04/20 and frequency of	F 684	1. Corrective action for this alleged deficiency was accomplished by the following: a) In-service provided to Staff and Licensed Nursing Staff on understanding and following Physician orders on the Physician Orders Sheet. (Attachment A) 2. Residents with the potential of being affected by the alleged deficient practice are all of the residents in the facility. However, with the implantation of the above, no residents will be affected. 3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: a) Director of Nursing and/or Designee will monitor during daily QA rounds. 4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent; a) The Administrator will monitor compliance through the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 684	Continued From page 5 every 4 hours for Acetaminophen 325 mg (milligram) tablet, take 2 tablets (650 mg) by mouth, not to exceed 3,000 mg in a 24 hour period. R2's record contains no documentation Acetaminophen by mouth or suppository was administered as ordered for a fever on these dates. R2's September 2020 POS contains a handwritten order dated 10/04/20 as follows - 02 @ (oxygen at) 2L NC (liters nasal cannula) prn (as needed) when sat (saturation) less than 90% (percent). Notify PCP (Primary Care Physician) if sats less than 92% with 02. On 10/16/20 at 2:15 PM, R2 was observed in her room lying in bed with no oxygen on and none available in her room. R2's Covid-19 Assessments also document her oxygen saturation as follows, in part: 10/16/20 at 8:00 AM - 84%; noon time and 4:00 PM are blank. A handwritten nurse's note by V8 (Registered Nurse) on this assessment dated 10/16/20 at 1:35 PM documents 02 88% RA. HOB (head of bed) elevated...respirations shallow and labored...will continue to monitor. R2's record does not contain documentation 02 was applied on this date. On 10/22/20 V3 and V8 (RN) stated they were not aware R2 had an order for oxygen. V8 stated he and the majority of regular staff were not working in the facility during the time the orders were written due to the majority quarantining at home after testing positive for Covid-19. Float staff were	F 684	process. b) The Quality Assurance team will monitor compliance through the quarterly Quality Assurance meetings. c) The Director of Nursing or Designee will monitor compliance during daily QA rounds.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 684	Continued From page 6	F 684		

here, and no one communicated this to them.

2. R3's record contains a Health Facility Transfer Chart from the local hospital with an admission date of 10/13/20, discharge with discharge orders dated 10/15/20, in part, to start Scopolamine transdermal patch 1 mg (milligram) 1 patch every 3 days.

R3's facility nursing note dated 10/15/20 at 10:00 AM documents R3 has returned from the local hospital via ambulance with comfort care ordered. R3's October POS documents a new order dated 10/15/20 for comfort care to include Scopolamine transdermal patch 1 mg (milligram) 1 patch every 3 days.

R3's October MAR dated 10/15/20 to 10/31/20 does not indicate R3 received the patch upon return to the facility this date. R3's record documents she passed away in the facility on 10/15/20 at 4:46 PM.

3. R5's October POS documents an order for "sling to be worn at all times." R5's October TAR (Treatment Administration Record) documents the same to include no lifting L (left) arm.

On 10/15/20 at 3:45 PM, V14 (Master of Physician Assistant Studies/Physician Assistant - Certified/ MPAS/PA-C) stated, "R5's left elbow was fractured, her elbow strap was filthy and caked with something, and I had to order a new one."

On 10/16/20 at 2:13 PM and again on 10/20/20 at 8:50 AM, 9:20 AM, and 12:11 PM, R5 was observed in bed with no sling on her left arm and arm was laying at her side. R5 stated her left arm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 684	Continued From page 7 was bothering her and she was supposed to keep it in a certain position. At 2:45 PM this day, R5 stated she was attempting to get out of bed a few weeks ago to make eggs for her son and fell. On 10/16/20 at 3:00 PM, when asked why R5's left arm was not in a sling, V3 (RN) stated she would look for one. V3 thought one had been ordered but had not come yet. On 10/20/20 when asked why R5's left arm was not in a sling, V3 stated it was in the laundry because she dropped food on it last night at dinner. V3 stated R5 did have a left arm fracture, but no surgery was required, only immobilization. On 10/23/20 at 10:04 AM, V19 (Medical Director/Primary Care Physician/PCP) stated the orders for R2, R3, and R5 should absolutely have been followed. V19 further stated, "Residents don't stand a chance to improve if these things are not done. I review my PA's notes; she is my right arm in the facility. Her orders are good, and the facility should follow them."	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		11/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 686	Continued From page 8 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to identify and implement interventions for individuals at risk for skin breakdown, failed to implement interventions to prevent further decline and promote healing to areas of existing skin breakdown for 2 (R1, R2) of 4 residents reviewed for pressure ulcers in the sample of 18. Findings include: On 10/15/20 at 3:45 PM, V14 (Master of Physician Assistant Studies/Physician Assistant - Certified/ MPAS/PA-C) stated she was in the facility today for the following, in part: "R1 has a bad stage 1 DTI (deep tissue injury) on bilateral heels and her heels are not being floated. R2 has a DTI on her right heel that concerns me. I gave the facility a telephone order on 10/12/20 to apply heels protectors, they are still not on, and her injury has worsened. R6 has a new area on the buttocks today." V14 further stated she took the adult brief off her residents and left orders to leave the adult briefs off in the future for skin care and healing purposes. 1. On 10/16/20 at 2:15 PM, R2 was observed in her room in bed, covered with blanket, eyes closed. Upon observation with V13 (Certified Nursing Assistant/CNA), a handmade appearing blanket with hand tied knot stitching had been placed under R2's calves making indentations in her skin. R2's heels were not floated and laying flat on the bed. R2's right heel was observed to have a deep red/dark purple/black area to the	F 686	. Corrective action for this alleged deficiency was accomplished by the following: A. Director of Nursing in-serviced Nursing staff on following Physician Orders in a timely and accurate manner. Date: 16NOV2020 B. R Director of Nursing in-serviced Nursing staff on the facility policy and procedures for repositioning and skin ailments. Date: 16NOV2020 2. Residents with the potential of being affected by the alleged deficient practice are all of the residents in the facility. However, with the implementation of the above, no residents will be affected. 3. A systemic review of facility systems including current policy and procedure was accomplished. This review found all procedures in compliance with State and Federal Guidelines. No further changes are required. 4. The following Quality Assurance practices will be implemented to ensure continual complicance: A. The Director of Nursing will monitor the repositioning and skin assessments of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 686	Continued From page 9 back right side with left heel red in appearance. R2's October POS (Physician's Order Sheet) documents a handwritten order given by V14 dated 10/12/20 to "float heels and apply heel protectors." At 2:23 PM, V8 (Registered Nurse/RN) stated heel protectors could not be located for R2. He stated he believed there was a telephone order from the PA dated 10/12/20 for this, he had called the front office and asked, but had not gotten any heel protectors yet. V8 stated R2's heels are floated, though. When told the blanket under R2's calves was leaving indentations on her calves, he asked what else should be used. 2. R1's October POS documents an order dated 10/15/20 as follows, in part: "feet elevated, heel protectors on at all times while in bed." On 10/16/20 at 3:00 PM, when asked about R1's heel protectors V3 (RN) stated, "They got wet and we sent them to laundry, then she was sent out to the hospital today before they were able to be put back on." V3 stated, "If residents are in bed when the heel protectors are being laundered, we float their heels." R1's record contains a hospital After Summary Care dated 10/16/20 to 10/18/20 with, "Other Instructions" to include, "turn every 1 hr (hour)." On 10/20/20 at 9:30 AM, R1 was observed lying flat on her back, feet/heels directly on bed. Right back of heel has dark red area. Heels not floated, no heel protectors. R1 was observed with V12 (CNA) and V18 (CNA) repositioning R1 from her current position down in the bed to the same	F 686	all residents. B. The facility Quality Assurance Team will monitor residents during their assigned rounds daily. C. The Quality Assurance Team will discuss concerns in the Morning QA Meeting daily for immediate resolutions. D. The Quality Assurance Team will review/revise assessments Quarterly or as needed. This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the Facility violated any federal or state regulation or failed to follow any applicable standard of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 686	Continued From page 10 higher position in bed, still on back with feet/heels directly on bed; at 11:11 AM, R1 was observed still in same position; at 11:40 AM, R1 was observed still in same position. At this time, V12 was asked how often was R1 turned and repositioned, and V12 stated, "Every 2 hours." When asked about the hospital discharge order to turn and reposition R1 every hour, V12 stated they were not aware of this and were only told to keep R1's oxygen on and do not put an [adult brief] on her. V12 stated she was also not aware R1 had a pressure area on her heel. At 11:50 AM, V2 (RN) stated R1 had been out to the hospital on 10/16/20 and came back on 10/18/20 with new discharge orders to include comfort care. V2 stated, "We go by the discharge orders." V2 stated the previous orders for heel protectors and float were not updated as of yet. When asked, V2 stated, "Yes, we can float heels as a nursing intervention without an order. I was not aware she had areas on her heels. I looked at her feet and toes, but not the bottom of her heels. I can put a pillow under her legs to float her feet." On 10/23/20 at 10:04 AM, V19 (Medical Director/Primary Care Physician/PCP) stated, "Absolutely the orders should have been followed, heels floated, 02 in place...turning and repositioning as ordered to avoid further skin breakdown. Residents don't stand a chance to improve if these things are not done. You have to at least try."	F 686		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		11/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 727	Continued From page 11 §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to designate a full-time Registered Nurse to serve in the role of Director of Nursing. This failure has the potential to affect all 29 residents who reside in the facility. Findings include: On 10/15/20 at 2:00 PM, V1 (Administrator) stated V2 (Registered Nurse/RN) stepped down from the Director of Nursing (DON) position and stated, "We currently have no DON." On 10/20/20 at 11:50 AM, V2 confirmed he was no longer the DON and they currently have no one in that position. Facility Daily Roster and census dated 10/15/20 documents there are currently 29 residents residing in the facility.	F 727	1. The corrective action for the alleged deficient practice has been achieved by the following: A. The facility hired a Director of Nursing on 9NOV2020. 2. All residents have the potential to be affected by the alleged deficient practice, however with the hiring of a current DON, no residents will be affected. 3. A systemic review of the facility systems including and procedures was accomplished. This review found that all procedures in compliance with State and Federal guideline. No further changes are required. 4. The following quality assurance measures will be implemented to insure compliance: A. The facility will continue to train the current DON to ensure success and all expectations of the position are fulfilled.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to administer an antibiotic as ordered by the physician for 1 (R3) of 6 residents reviewed for medication administration in a sample of 18. This failure caused a delay in treatment of R3's urinary tract infection causing R3 to become septic and requiring a hospital admission for treatment. Findings include: On 10/21/20 at 2:45 PM, V25 (Family Member) stated R3 went to the hospital on 10/05/20 and was diagnosed with a UTI (Urinary Tract Infection). V25 stated R3 was sent back to the facility that evening with orders to start taking an antibiotic. V25 stated during a phone conversation with the facility on 10/08/20, V29 (Family Member/Power of Attorney/POA) became aware staff did not know R3 was supposed to be taking an antibiotic. V25 stated there was a 3-day delay in R3 receiving this medication and R3 got worse as a result to the point she had to go back to the hospital and had severe sepsis and her kidneys had started to shut down. R3's hospital record dated 10/05/20 documents diagnoses, in part for "Today's Visit" as urinary tract infection without hematuria; Start taking LevoFloxacin 500 mg (milligram) tablet 1 by mouth once daily for 7 days. A handwritten note on this hospital record under this antibiotic order documents, "noted 10/08/20 by V22 (Registered	F 760	1. The corrective action for the alleged deficient practice has been achieved by the following: A. Licensed nursing staff were in-serviced on 16NOV2020 on dispensing medications to ensure that medications are given as soon as they arrive in the facility. (See attachment A) B. Director of Nursing/designee will review Physician Order sheets weekly for accurate transcription and completion of orders and variances in policy will be addressed as appropriate with staff. 2. This alleged deficiency could potentially affect all residents residing in the nursing home facility. However, with the implementation of the above and the quality assurance measures mentioned in this Plan of Corrections, the alleged deficient practice will not recur. 3. Systemic review of facility systems including current policy and procedure was accomplished. This review found all procedures in compliance with State and Federal Guidelines. No further changes	11/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 760	Continued From page 13 Nurse/RN)." R3's nurse's notes document the following, in part: 10/08/20 - 2:30 PM - V29 called to check on resident's condition r/t (related to) ER (emergency room) visit on 10/05. Upon review of chart discovered med discrepancy. Levaquin 500 mg was ordered for 7 days to treat UTI. Admin (administrator) notified and MAR (Medication Administration Record) and POS (Physician's Order Sheet) corrected; 2:40 PM - V19 (Primary Care Physician - PCP) notified of med error and med ordered from pharmacy; 10:00 PM - Started po (by mouth) Levaquin 500 mg will monitor for ADR (adverse drug reaction). R3's POS dated 10/01/20 to 10/31/20 documents a handwritten note under physician's orders dated 10/05/20 as: 1) Levaquin 500 mg qd (every day) x 7 days - UTI. R3's October MAR documents a handwritten medication dated 10/05/20 for Levaquin 500 mg po qd x 7 days at 8:00 PM for UTI. This MAR confirms R3 received her first dose of Levaquin on 10/08/20 at 8:00 PM. On 10/16/20 at 1:33 PM, V3 (Registered Nurse/RN) stated, "We get new orders, but they are received on the front side office fax machine. Due to Covid-19 someone from the 'clean side' will bring our faxes around to our outside door when we get one, since all the residents reside on the Covid-19 wing at this time." R3's record documents a hospital admission on 10/13/20 and discharge back to facility on 10/15/20 for end of life/comfort care with the following diagnoses, in part: Acute cystitis with	F 760	are required. 4. The following measures will be carried out as part of the facilities ongoing Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and permanent: A. The DON/designee will monitor all orders during the 24 hour Nurse Report during Morning QA meeting and will ensure all Physician Orders are completed. B. Concerns will be discussed at the Morning QA meetings as needed for immediate resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 760	Continued From page 14 hematuria, sepsis, and severe sepsis. On 10/23/20 at 10:04 AM, V19 (Physician) stated, "...the delay in antibiotic directly contributed to R3 going septic. ABX (antibiotics) treat the bug in the urine and if not given the infection goes to the blood stream. This could have been avoided..." V19 confirmed he oversees V14's (Master of Physician Assistant Studies/Physician Assistant - Certified/ MPAS/PA-C) notes and the facility should be following her orders. V19 stated, "V14 is 'my right hand'."	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 000	INITIAL COMMENTS Complaint Investigation 2058211/IL127809 - No Deficiency 2058243/IL127841 A Focused Infection Control Survey/COVID-19 Focused Survey was conducted by the Illinois Department of Public Health on October 23, 2020. Survey Census: 29	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		11/16/20

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

Electronically Signed | 11/17/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 880	Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to use an EPA (Environmental Protection Agency) approved disinfectant effective against the Covid-19 virus to mop their floors. This has the potential to affect all 29 residents who reside in the facility. Findings include: A Facility Roster and Census dated 10/15/20 documents there are currently 29 residents residing in this facility. On 10/16/20 at 1:26 PM, V5 (Housekeeping) was observed mopping the activity room on northwest side of the facility. V5 stated he was using the multi-task 5 system century maintenance for the floors. V5 stated, "We squeeze the bottle until it comes up to the line and add this to 2 gallons of water." V6 (Housekeeping Supervisor) confirmed this product was used to mop the facility floors. On 10/21/20 at 11:27 AM, V1 (Administrator) was asked to provide clarification regarding the EPA number previously provided for the Multi-task systems 5 Century Maintenance product, as it was not on the list of disinfectants effective against Covid-19. V1 provided an additional number at this time. On 10/21/20 at 1:30 PM, V28 (Chemical Supply Company Agent) confirmed the Multi-task system 5 Century Maintenance was not a disinfectant and not effective against Covid-19. V28 stated it is used as an all-purpose cleaning product and	F 880	1. For the building floors to have been potentially affected by the alleged deficient cleaning product, the following corrective action was implemented. A) The facility Administrator In-serviced the Housekeeping personnel to the facility Covid-19 cleaning procedures. Date: 16NOV2020 (Attachment A) B) The facility Housekeeping and Maintenance Supervisors conducted an audit of all cleaning supplies to ensure reliability to combat Covid-19. Date: 16NOV2020 2. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of the above corrective action; alleged deficient practice will not reoccur. 3. A systemic review of the facility systems including policy and procedures was accomplished. This review found that all policy and procedures in compliance with State and Federal guidelines. No further changes are required. 4. The following Quality Assurance programs have been implemented to ensure continued compliance. A. The Quality Assurance Committee will assure compliance through the internal Quality Assurance Process. B. The facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145624	A. BUILDING _____ B. WING _____	10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	**701 SHADWELL AVENUE FLORA, IL 62839**

(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
F 880	Continued From page 3 provided the product information/specification sheet.	F 880	Administrator/Housekeeping personnel will maintain the Covid-19 cleaning procedure policy. C. The Quality Assurance Committee will discuss Infection Control weekly in the QA Morning meeting and Quarterly to identify trends. D. The Administrator will complete random visual observations of the floor cleaning procedures to ensure compliance with recommended Covid-19 disinfecting guidelines.	