STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 Annual Certification Survey Complaint # 1663829 / IL 86862 - no deficiency	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		7/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 156	Continued From page 1	F 156		

including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 156	Continued From page 2 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide a complete written liability notice for Medicare Part A non coverage for therapy services to one (R8) of 10 sampled residents and two residents in the supplemental sample (R22 and R23) reviewed for Medicare Beneficiary Liability and Appeal notices. The finding includes: The facility provided a list of residents that were discharged from Medicare Part A. Three of the most recent discharged resident's notices were reviewed. R8 was discharged from Medicare on 7-8-16. R22 was discharged from Medicare on 6-18-16. R23 was discharged from Medicare on 7-12-16. The facility was unable to provide documentation that R8, R22 and R23 had received the Medicare Beneficiary Liability and Appeal notices. E2, Director of Nurses stated on 7-19-16 at 9:12 A.M., that the facility was not providing the "Notice of Medicare Provider Non-Coverage" (CMS-10123) to discharged Medicare residents. E2 confirmed that R8, R22 and R23 did not receive the written notice.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 156	Continued From page 3 The "Notice of Medicare Provider Non-Coverage" (CMS-10123) includes the type of services that were no longer being covered by Medicare and the name and the toll-free number of Quality Improvement Organization (QIO). The QIO information is necessary for the resident if the resident would request an appeal of the facility decision. The notice of Medicare Provider Non-Coverage" (CMS-10123) explains beneficiary appeal rights.	F 156		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to operationalize their physical restraint policy for one of two residents (R17) reviewed for physical restraints in the sample of ten. Specifically, the facility failed to demonstrate the medical necessity for the ongoing use of a physical restraint, failed to develop and implement a plan of care to assure physical restraint reduction, and failed to ensure that the physical restraint was removed when indicated. Findings include: The Facility's "Use of Physical Restraint Policy" dated 4/15/2011 documents, "...Physical	F 221		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 221	Continued From page 4 Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body...The definition of a restraint is based on the functional status of the resident an not the device. If the resident cannot remove a device in the same manner in which the applied it given that resident's physical condition and this restricts his/her typical ability to change position or place, that device is considered a restraint...The opportunity for motion and exercise is provided for a period of not less than ten minutes during each two hours in which restraints are employed..Restrained residents must be repositioned at least every two hours on all shifts..Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use..Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use..." R17's Physical Restraint (Initial Evaluation) dated 6/2/14 documents R17's behavior prompting restraint use as unsteady gait, forgetting ambulation device, frequents falls, sliding out of wheelchair, and attempts at self transfer. This evaluation documents R17 has impaired cognition. Recent (medication) reductions have made her more alert, but more active. This evaluation also documents R17 overestimates capabilities and tries to ambulate/transfer self. This evaluation documents R17 has an order for, "Self releasing belt to be worn while in wheel chair. Remove for 10 minutes every two hours and as needed." R17's Physical Restraint (Quarterly/Annual	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 221	Continued From page 5	F 221		

Evaluation) dated 6/3/16 documents, "Res (resident) (R17) becomes anxious and agitated often. Attempts to self transfer at times.. no plans to reduce..will continue with self releasing seat belt restraint for safety of resident."

R17's Restraint Care Plan dated 6/23/15 documents, "The resident (R17) has a physical restraint. Self releasing belt in wheelchair per family request r/t (related to) Confusion." R17's Restraint Care Plan does not include interventions to provide R17 with the opportunity for motion and exercise. R17's Restraint Care Plan does not include the measures taken to systematically reduce or eliminate the need for restraint use.

On 7/18/16 at 9:30 AM, R17 was sitting across from the nurse's station in R17's wheelchair with seat belt buckled.

On 7/18/16 at 11:10 AM, R17 was sitting in a wheelchair in the hallway, R17's seat belt was buckled and R17 was attempting to stand.

On 7/18/16 at 11:12 AM, E14 Registered Nurse asked R17 to undo R17's seat belt. R17 could not unfasten seat belt when asked. E14 then asked R17 to pull on red part of seat belt, after stating this to R17 multiple times E14 then pulled on red part of the seat belt undoing the seat belt. At that time, E14 stated R17 could not remove seat belt when asked until R17 was given directions to remove. R17's seat belt was then refastened immediately.

On 7/18/16 at 12:20 PM, R17 was sitting in the dining room at the dining room table and R17 was wearing R17's seat belt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 221	Continued From page 6 On 7/18/16 at 1:15 PM, R17 was taken to R17's room for cares. At that time R17's seat belt was removed to provide cares. On 7/20/16 at 9:30 AM, R17 was sitting across from the nursing desk in the wheel chair, R17's seat belt was in place. On 7/20/16 at from 12:20 PM to 12:55 PM, R17 was sitting at the dining room table and R17's seat belt was in place. On 7/20/16 at 12:55 PM, E15 Certified Nurse's Assistant stated E15 cared for R17 on 7/18/16 and 7/20/16 during the dayshift (6:00 AM to 2:00 PM). E15 stated E15 put R17's seat belt on before breakfast (8:00 AM) on both days and did not remove it on either day until after lunch. E15 stated E15 does not know if R17 has a restraint care plan. E15 stated as far as E15 knows when R17 is in the wheelchair the seat belt is to be on. E15 stated E15 only removes it when R17 is put to bed or when R17 is toileted. E15 stated R17 usually stays up during the day. E15 stated R17's seat belt is not removed during activities. On 7/20/16 at 9:40 AM, E3 Assistant Director of Nursing stated R17's seat belt helps with supervising R17 and keeping R17 safe. R17's seat belt is to be on while R17 is in the wheelchair and removed when R17 is in bed. E3 stated there is not a reduction plan for R17's restraint.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 241	Continued From page 7 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to position R20 in the dining room to promote dignity. R20 is one of six residents reviewed for dining in the sample of 10. Findings include: R20's Physician's Order Sheet dated 7/1/16 documents R20's diagnoses including Dementia with Behaviors, Anxiety and Depression. R20's Minimum Data Set dated 4/24/16 documents R20 is dependent (total assist) for all (Activities of Daily Living) ADL's including eating. On 7/18/16 at 12:11pm and 12:50pm, 7/19/16 at 11:50am and 7/20/16 at 8:27am, R20 was positioned with the back side of the wheelchair to the table with R20 facing toward the middle of the dining room away from the table. There were no behaviors observed at these times. On 7/19/16 at 2:00pm, E9, Certified Nursing Assistant (CNA) stated the facility positions R20 with back side of the wheelchair toward the table facing away from R20's table at each meal daily to be able to feed her more easily. E9 did not believe the facility has tried to move R20 to accommodate R20's positioning needs. On 7/20/16 at 8:40am, E3, Assistant Director of Nursing (ADON) stated, "I {E3} do think it is a dignity issue."	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to conduct a comprehensive assessment after a significant change in condition for one of ten residents (R17) reviewed for resident assessment instruments in the sample of ten. Findings include: R17's Annual Minimum Data Set dated 12/06/15 documents R17 is understood and has no verbal behavioral symptoms. This assessment documents R17 requires limited assistance of one person to walk in the room and to walk in the corridor, limited assistance of one person for locomotion on and off the unit and required limited assistance of one with personal hygiene. This assessment also documents R17's weight as 167 pounds and that R17 has no use of	F 274		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 274	Continued From page 9 restraints. R17's Quarterly Minimum Data Set dated 6/5/16 documents R17 is sometimes understood and has verbal behavioral symptoms affecting others one to three days per week. This assessment also documents R17 did not walk in room or corridor, required extensive assistance of one for locomotion on and off the unit and extensive assistance of one with personal hygiene. This assessment documents R17's weight as 150 pounds and that R17 uses a trunk restraint daily. This Minimum Data Set is not marked as a significant change in assessment and a comprehensive assessment was not completed. On 7/18/16 at 9:30 AM, 11:10 AM, and 12:20 PM, R17 was sitting in a wheelchair with a seatbelt. On 7/18/16 at 1:00 PM, R17 was pushed into the room by E15 Certified Nurse's Assistant. On 7/20/16 at 9:40 AM, E3 Assistant Director of Nursing stated E3 did not complete a comprehensive assessment on 6/5/16. E3 stated E3 should have conducted a comprehensive assessment and coded R17's 6/5/16 Minimum Data Set as a significant change in assessment due to changes in R17's activities of daily living and significant weight loss. The facility's Change in a Resident's Condition or Status dated 4/28/15 documents, "....If a significant change in the resident's physical or mental condition occurs, the assessment team will evaluate the need for a comprehensive assessment of the resident's condition."	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 278	Continued From page 10 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately complete a Minimum Data Set for one of ten residents (R17) reviewed for Resident Assessment Instruments in the sample of ten. Findings include:	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 278	Continued From page 11 R17's Minimum Data Set (MDS) dated 12/6/15 documents R17's weight as 167 pounds. R17's MDS dated 6/4/16 documents R17's weight as 150 pounds. R17's MDS documents a zero (no) weight loss of five percent or more in the last month or of loss of ten percent in the last six months. On 7/20/16 at 9:40 AM, E3 Assistant Director of Nursing stated she is the coordinator of the MDS assessments. E3 stated R17's MDS dated 6/4/16 should have documented R17 as having a ten percent weight loss. E3 confirmed that R17's 6/4/16 MDS was miscoded.	F 278		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide services to maintain or improve abilities in the areas of ambulation and eating for two of three residents (R17, R19) reviewed for need for increased activities of daily living in the sample of ten. Findings include: 1. R17's Minimum Data Set (MDS) dated 12/6/15 documents R17 can ambulate with limited assistance of one person on and off the unit.	F 311		8/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 311	Continued From page 12	F 311		

R17's MDS dated 6/5/16 document R17 does not ambulate on or off the unit and that R17 is not receiving restorative nursing programming.

On 7/18/16 at 1:00 PM, R17 was pushed in a wheelchair from the dining room to R17's room by E15 Certified Nurse's Assistant.

On 7/20/16 at 9:40 AM, E3 Assistant Director of Nursing stated there are no restorative nursing programs in the building. E3 stated nothing has been done to maintain or prevent a decline in R17's ambulation. E3 stated R17 will become combative with staff at times and that's probably why they quit walking R17. E3 stated the facility does not have a staff member responsible for restorative programs.

R17's Care Plan dated 6/5/16 does not include interventions to improve ambulation or to ambulate R17.

The facility's Restorative Program Policy dated 11/21/11 documents, "ambulating will be encouraged for all residents on a daily basis...formal written Restorative Programs are found in resident careplan to be carried out by staff and are monitored at least monthly and documented on/or with change of condition by restorative nurse."

2. R19's MDS dated 4/24/16 documents R19 requires assistance of one person with eating. R19's MDS documents that R19 is not receiving any restorative nursing programs.

On 7/18/16 at 12:20 PM, R19 was attempting to place cauliflower on R19's fork. R19 was pinching

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 311	Continued From page 13 the end of the handle of the fork with R19's first finger and thumb and the fork was moving up and down. R19 was unable to place food on the fork. E15, Certified Nurse's Assistant (CNA) then took fork from R19 and fed R19. On 7/20/16 from 12:20 PM to 12:55 PM, R19 was sitting at the staff assisted dining table. R19 was eating lunch by picking up the food with R19's fingers. R19 attempted to pick up a spoon but was unable to do so. R19 continued to eat carrots and beef stroganoff with R19's fingers. On 7/20/16 at 12:55 PM, E15 stated R19 eats with fingers a lot. E15 stated R19 can sometimes eat with a utensil but eating with R19's fingers is easier. E15 stated E15 has worked here three years and R19 has never used adaptive utensils and has not been on an eating program. On 7/20/16 at 1:15 PM, E2 Director of Nursing stated R19 has not been assessed for a eating program or been evaluated for an adaptive utensil. E2 stated R19 should not be eating with fingers and an adaptive utensil should be attempted.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 314	Continued From page 14	F 314		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to accurately identify a pressure ulcer and failed to seek nutritional reassessment for a newly acquired pressure ulcer for one of three residents (R20) reviewed for impaired skin in the sample of 10.

Findings include:

R20's Progress Notes dated 7/4/16 at 1:33 pm, document R20 has a fluid filled blister on the left outer heel.

R20's Skin Observation Tool dated 7/4/16 at 1:37 pm, documents R20's left heel blister with measurements of 2 cm. (centimeters) by 1.5 cm. The area to document "stage" of the wound is blank. R20's Skin Observation Tool dated 7/14/16 documents at 12:06 am R20's left heel blister but there are no measurements or stage documented.

R20's nutritional care plan is dated 8/24/15 and does not include updates with nutritional interventions or approaches in regards to R20's left heel blister. There is no documentation of any nutritional interventions in regards to R20's left heel blister pressure ulcer.

There is no documentation that E11, Dietician or the facility's wound care consultant was notified of R20's wound.

On 7/19/16 at 9:30am, E2, Director of Nursing (DON) stated the nursing staff is supposed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 314	Continued From page 15	F 314		

document approximate measurements (of wounds) at least weekly. E2 stated the nurses are to notify the E10, Licensed Practical Nurse who will notify the wound care company and chart the notification. E2 stated the wound care company and E11, Dietician should have been notified.

On 7/20/16 at 9:20 am, E2, DON stated E2 could not find documentation that the Dietician had been notified or seen R20 for R20's newly acquired left heel blister pressure ulcer. E2 stated E2 would expect the nurse to notify E3, Assistant Director of Nursing (ADON) of new wounds as soon as possible. E2 stated R20's blister should have been passed on to E3, ADON and followed up on with E11, Dietician and the wound care company on 7/5/16 or as soon as possible.

On 7/20/16 at 9:30 am, E3, ADON stated, "{E3} was only aware {R20} had a blister. {E3} didn't know the blister was a pressure ulcer."

The facility's wound company's undated document titled, "Frequently Asked Questions" documents, "What if there are new wounds since the last visit by my Wound Education Specialist... send a comment to your Wound Education Specialist..."

The facility's Routine Skin Policy dated 5/1/12 documents, "If new skin problems develop... fill out wound documentation sheet. Pressure ulcers will be assessed weekly and documented on pressure ulcer form..."

The facility's Cutaneous Wounds, Abrasions, and Minor Irritation policy dated 11/16/11 documents, "Routine Skin Policy- will be part of each... resident chart to be followed... If skin problems

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 314	Continued From page 16 develop; reassess immediately... Notify... dietary, wound nurse, DON/ADON..." The facility's Skin Care Protocol and Prevention of Pressure Ulcers policy dated 3/28/11 documents, "... Dietician or Dietary Supervisor to evaluate... with significant change in condition. Individual care plan interventions will be implemented... Provide with protein supplements 2 times a day until evaluated by the Dietician..."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure indwelling urinary catheter tubing and urinary catheter collection bag was kept off of the floor for one of one resident (R2) reviewed for indwelling urinary catheters in the sample of 10. Findings include: R2's Physician Order Sheet dated 9/26/13 documents an order for a urinary catheter for	F 315		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 315	Continued From page 17 unspecified retention of urine. On 7/18/16 at 12:31 PM, R2 was sitting in the dining room in R2's wheelchair with R2's indwelling urinary catheter tubing lying on the floor underneath R2's wheelchair. On 7/19/16 at 10:00 AM, E16 Certified Nurse Assistant (CNA) transferred R2 from the wheelchair to the bed. E16, CNA took the indwelling urinary catheter bag from behind R2's wheelchair and put it on the floor to the front of the wheelchair. E16 then picked up the indwelling urinary catheter bag from the floor and hooked it on the side of R2's wheelchair. After providing cares, E16 CNA assisted with R2's transfer back into the wheelchair leaving the indwelling urinary catheter tubing lying on the floor. On 7/19/16 at 1:10 PM E9, CNA placed R2's indwelling urinary catheter bag on the floor. On 7/19/16 at 1:25 PM, E9, CNA stated "I put the catheter (urinary) bag on the floor to move it... the catheter bag or tubing cannot be touching the floor." On 7/21/16 at 10:15 AM, E2 Director of Nursing (DON) stated "the bag (urinary catheter) has to be picked up to be moved....tubing (urinary catheter) should not touch the floor....the catheter bag should not be on the floor." R2's Care Plan dated 3/8/16 documents catheter care every shift for "(indwelling) catheter." The facility's Indwelling Catheter Care Policy dated 6/17/2011 documents "....catheter bag is to	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 315	Continued From page 18 be off the floor."	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement assessed and planned contracture interventions to prevent decline in Range of Motion (ROM) for one of one resident (R2) reviewed for ROM/contractures in the sample of 10. Findings include: R2's Care Plan dated 3/8/16 documents to place a rolled washcloth or cone in the palm of R2's hands. On 7/18/16 at 12:31 PM, R2 was sitting in R2's wheelchair in the dining room. R2 did not have washcloths or cones in either hand. On 7/18/16 at 2:55 PM, R2 was lying in bed with no washcloths or cones in either hand. On 7/19/16 at 10:00 AM and 10:10AM, R2 was sitting in R2's wheelchair without washcloths or cones in either hand.	F 318		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 318	Continued From page 19 On 7/19/16 at 12:16 PM, R2 was sitting in the dining room with no washcloths or cones in either hand. On 7/19/16 at 1:10 PM, R2 had no washcloths or cones in either hand. On 7/19/16 at 1:40 PM E15, Certified Nursing Assistant (CNA) stated R2 should have something in R2's hands at all times due to R2's contractures. On 7/21/16 at 10:15 AM E2, Director of Nursing (DON) stated a washcloth or cone should be in both of R2's hands at all times. The facility's Restorative Program Policy dated 11/21/2011 documents "handrolls... use whenever hands are contracted or beginning to show signs of contractures."	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 329	Continued From page 20 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to monitor targeted behaviors being treated with psychotropic medication and failed to attempt non-pharmacological interventions for one of two residents (R17) reviewed for antianxiety medications in the sample of ten. Findings include: R17's Medication Administration Sheet dated July of 2016 contains an order for Ativan 0.5 milligrams by mouth every morning and Ativan 0.5 milligrams by mouth every six hours as needed for a diagnosis of Anxiety. R17's Psychiatric Visit report dated 7/8/16 documents R17 receives Ativan for monitored behaviors of Confusion and Agitation. R17's Care Area Assessment dated 7/19/16 documents R17 receives an antianxiety medication due to restlessness and agitation. R17's Care Plan dated 6/5/16 documents R17 receives an antianxiety medication related to a	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 329	Continued From page 21 history of anxiety. R17's care plan goal is to show a decreased number of episodes of anxiety through the review date. R17's Care Plan includes an intervention to monitor and record the occurrence of target behavior symptoms and document on behavior sheets per facility protocol. This care plan does not include non pharmacological interventions for targeted behaviors. This care plan does not list R17's targeted behaviors of restlessness or agitation. R17's Quarterly Psychoactive Medication Assessment dated 6/3/16 documents R17 as receiving Ativan 0.5 milligrams every six hours as needed for a diagnosis of Anxiety. This assessment does not state what R17's targeted behaviors are or an analysis of R17's behaviors. This assessment does not document what nonpharmacological interventions have been attempted or implemented or an analysis of the effectiveness of these interventions. R17's Point of Care documentation for behaviors dated July of 2016 does not include a place to document behaviors of anxiety or agitation. On 7/20/16 at 11:30 AM, E2, Director of Nursing stated no one in the facility is monitoring the frequency of R17's targeted behaviors. E2 stated no one in the facility is monitoring the effectiveness of nonpharmacological interventions or reassessing which nonpharmacological interventions are effective. E2 stated the floor nurses complete the Psychoactive Medication Assessments and it is not always the same nurse. E2 stated no one in the facility is responsible for analyzing the Psychoactive Medication Assessments for changes in the resident's assessments.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that three of three open flame gas clothes dryer heat exchangers were free of dust and lint which create a potential fire hazard. The facility also failed to ensure that potentially hazardous chemicals were stored in a locked room or cabinet at four locations. These failures have the potential to affect all 22 residents who reside in the facility. The findings include: 1. On 7-19-16 at 7:56 A.M. the laundry area was observed with E4, Maintenance Director. Dust and lint was in the dryer cabinet seams, in the heat exchangers and on the back of the three open flame gas dryers. E4 stated that E4 did not know when the driers were last cleaned. 2. On 7-19-16 between 7:35 A.M. and 9:05 A.M. while accompanied by E4, the lavatory cabinet at the West Nurses Station was unlocked. The cabinet contained two spray bottles of a quaternary ammonia disinfectant. The West Soiled Utility Room was unlocked and contained two spray quart bottles of quaternary ammonia disinfectant on the top of the counter. Two spray quart bottles of quaternary ammonia disinfectant and a spray quart bottle of a bleach solution were	F 465		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 465	Continued From page 23 on the counter in the unlocked East Soiled Utility Room. Two unlabeled spray bottles were hanging on the grab bar in the unlocked East shower room. These unlocked rooms are accessible to residents. According to the facility's "Resident Census and Conditions of Residents" dated 7-19-16, 22 residents reside in the facility.	F 465		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

(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 520	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct quarterly Quality Assessment (QA) meetings to identify and implement quality improvement measures. This failure has the potential to affect all 22 residents who reside in the facility. Findings include: On 7/19/16 at 1:20pm, E3, Assistant Director of Nursing (ADON), stated the QA committee is supposed to meet every three months. E3 stated the QA meeting that was scheduled for January 2016 was canceled and that the facility had not had a QA meeting "in a while." On 7/19/16 at 1:38pm, E2, Director of Nursing stated QA meetings are to be done quarterly. E2 stated the facility has not had any meetings since E2 started as the DON in February 2016. On 7/19/16 at 2:30pm, E2 provided one "Quality Assurance" record dated 10/15/15. E2 stated there is no other documentation that QA meetings have been completed quarterly. The facility's Resident Census and Condition of Residents report dated 7/19/16 documents 22 residents reside in the facility.	F 520		