STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145842	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flanagan Rehabilitation & Hcc	201 East Falcon Highway Flanagan, IL 61740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility Social Services Director failed to conduct follow up visits following an abuse allegation for one resident (R3) of five residents reviewed for abuse from a sample list of five residents. Findings include:The facility's Abuse policy dated 3/25 documents that Social Service will follow up with any residents after an allegation is made and document the visit in the chart of the resident.R3"s Nursing Note dated 6/4/2025 at 4:45PM documents the Interdisciplinary Team (IDT) met to follow up on R3's recent allegation against a staff member. The investigation was completed, and the allegation was unfounded. R3's reportable dated 5/22/25 stated social service will meet with R3 twice a week for the next four weeks.R3's Quarterly Minimum Data Set, dated [DATE] documents R3 is cognitively intact and R3 reported V7 and V11 Certified Nursing Assistants (CNA's) to the facility. It was noted R3 has a history of Post Traumatic Syndrome Disorder (PTSD) and V4 did not speak with R3 following the incident.On 6/30/2025 at 3:45PM, V4 (Social Service Director) stated she didn't talk to resident after the allegation and she didn't document it as it slipped V4's mind.On 7/1/2025 at 10:15AM, V1 (Administrator) stated V4 did not follow up with R3 and should have along with documenting the interaction in R3's chart as noted in the facilities Abuse policy and the report related to the allegation.

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.

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