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	09/18/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to ensure care plans included problems, goals, and interventions to address diagnoses and medication use for two of three residents (R2, R3) reviewed for medications in the sample list of three. Findings include:1.) R2's active diagnoses list includes epileptic seizures related to external causes, not intractable, without status epilepticus. R2's September 2025 Medication Administration Record (MAR) documents R2 receives Lamotrigine 200 milligrams (mg) by mouth twice daily for seizures since 2/3/24 and Phenytoin Sodium100 mg give two capsules by mouth twice daily for seizures since 5/24/25.R2's active care plan does not include a problem, goal, and interventions for R2's seizure disorder and seizure medications. On 9/18/25 at 12:55 PM V2 Director of Nursing confirmed R2's seizure disorder and seizure medications were not on R2's care plan. V2 stated V2 is responsible for updating the care plans and V2 will update R2's care plan. 2.) R3's September 2025 MAR documents R3 receives Tramadol (opioid) 50 mg one tablet by mouth daily since 4/18/23. R3's active care plan does not have a problem, goal, and interventions for opioid use and monitoring, including risk for constipation. On 9/18/25 at 12:55 PM V2 confirmed R3's care plan does not address Tramadol use, interventions, and risk for constipation. V2 stated V2 will need to update R3's care plan.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement a bowel program for one of three residents (R3) reviewed for medications in the sample list of three. Findings include:R3's August and September 2025 Medication Administration Records document R3 receives Tramadol (opioid) 50 milligrams by mouth daily since 4/18/23 and Milk of Magnesia 30 milliliters daily as needed for constipation. These records document R3 does not receive any scheduled bowel medications and did not receive any doses of Milk of Magnesia. R3's Minimum Data Set, dated [DATE] documents R3 has severe cognitive impairment and requires dependence on staff for toileting hygiene. R3's active care plan does not address R3's Tramadol use and monitoring, including risk for constipation. R3's Bowel Tracking Report with date range 8/20/25-9/18/25 documents the following: Large on 8/20/25. None 8/21/25-8/23/25. Large on 8/24/25. None 8/25/25-8/27/25. Large on 8/28/25. None 8/29/25-9/1/25. Large on 9/2/25. None on 9/3/25 and 9/4/25. Large on 9/5/25. Two to three daily 9/6/25-9/8/25. Once on 9/9/25 and 9/10/25. None 9/11/25-9/13/25. Large on 9/16/25. None 9/17/25 and 9/18/25. R3's Nursing Notes with range 8/15/25-9/18/25 do not document R3 was assessed for constipation, offered Milk of Magnesia, or offered any other bowel interventions. On 9/18/25 at 11:29 AM V4 Registered Nurse stated the (electronic medical software) triggers an alert if a resident doesn't have a bowel movement (BM) for three or more days. V4 stated the Certified Nursing Assistants (CNAs) document the residents' BMs. V4 stated R3 has Milk of Magnesia to administer daily as needed. V4 stated R3 has occasional constipation, but nothing frequent. V4 confirmed R3 does not have orders for any other bowel medications. On 9/18/25 at 11:55 AM V3 CNA stated V3 is assigned to R3's care today and R3 has not had a BM today. V3 stated BMs are documented by the CNAs in (electronic medical software) and complaints of constipation are reported to the nurses. V3 stated R3's BMs are generally soft, but R3 has constipation about once per week. On 9/18/25 at 12:55 PM V2 Director of Nursing confirmed R3's care plan does not address opioid use and monitoring, including risk for constipation. V2 stated the facility has a bowel protocol to follow, which V2 will provide. V2 stated the (electronic medical software) sends an alert after three full days have passed with no BM, and continues to alert until addressed/resolved with BM documented. V2 reviewed R3's bowel tracking 30 day report, and confirmed duration of days with no BMs recorded. V2 stated R3 had BMs on day four, so the system would not have prompted an alert. V2 stated V2 will have to see if the system can be changed to alert on day two. V2 stated V2 would expect Milk of Magnesia to be given on day four of no BM. V2 stated V2 might look into getting R3 something scheduled routinely for R3's bowels. V2 confirmed risk of constipation with opioid use. At 2:45 PM V2 stated V2 followed up with corporate staff, and the facility does not have a bowel protocol; it is individually based on each resident's needs and bowel patterns. V2 stated it would also be based on if the resident was experiencing any symptoms such as nausea, vomiting, decreased appetite; which R3 has not had.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed ensure a controlled medication was not stopped abruptly without notifying the physician for one of two residents (R1) reviewed for medication errors in the sample list of three. This failure resulted in R1 becoming unresponsive, falling, and being transferred to the hospital with benzodiazepine withdrawal, delirium, and syncope after R1's Ativan (benzodiazepine) was stopped abruptly. Findings include:R1's Minimum Data Set, dated [DATE] documents R1 has moderate cognitive impairment. R1's active Care Plan dated 7/18/25 documents the following: R1 has anxiety and intellectual developments. Interventions include give medication as ordered and monitor/document side effects and effectiveness, and to monitor for signs/symptoms of behaviors. The Care Plan documents R1 has diagnoses of Developmental Intellectual Disability, Depression and Anxiety Disorder. R1's July, August and September Medication Administration Record (MAR) documents a physician order from the Hospital dated 7/18/25 for Ativan (Benzodiazepine) 1mg (milligram) three times a day. Pharmacy Records document the pharmacy filled the medication script of 1mg of Ativan on 7/18/25, 8/2/25, 8/14/25, and 8/28/25 for 15 days each refill day with 45 capsules. R1's MAR documents Ativan 1mg three times a day was stopped on 9/6/2025. The Nursing Control Medications sheet dated 9/6/25 documents that 32 Ativan pills were wasted with two nurse witnesses. Nursing Notes dated 9/9/2025 at 9:24AM document facility staff requested a signed prescription for R1's Ativan. The Pharmacy Receipt dated 9/11/25 documents the pharmacy received the signed prescription for 1mg Ativan three times a day. R1's Nursing notes dated 9/11/25 at 2:46pm document Nurse was in next room and heard a thud. Went into residents' room and observed resident on the floor laying supine with her head in the corner of her closet and the wall. Resident unresponsive. Pulse and respirations present. 911 called. MD (Medical Doctor), POA (Power of Attorney), DON (Director of Nurses), and transport notified. Resident put on backboard and neck stabilized. No physical injury observed. VS (vital signs) taken; blood sugar taken. EMS (Emergency Medical Services) arrived 1455 (2:55 PM). Resident slowly began to become more responsive. R1's Medical Record documents R1 was admitted to the hospital on [DATE] with a diagnosis of Benzodiazepine Withdrawal with Delirium and Syncope and Collapse.Nursing Progress Notes dated 9/16/25 at 12:23PM document, The interdisciplinary team met and resident's family and hospital were concerned that resident had a seizure related to Ativan discontinuation, spoke with Medical Director and resident will resume Ativan at current dose and will remain on it indefinitely.On 9/18/25 at 8:17AM, V4 (Registered Nurse), stated V4 was the nurse on duty that day and heard a thud and responded. V4 stated R1 was lying in the corner by the closet, lying flat on her back, her skin was cool and clammy and R1's blood pressure was high. V4 stated she called for the emergency crash cart as R1 was unresponsive and called 911 to send R1 to the Emergency Room. On 9/18/25 at 11:13AM, V5 (Pharmacist) stated a 3mg daily dose of any Benzodiazepine would be considered a high risk medication and should have been decreased gradually continuously for two months. V5 also stated that risk factors include, seizures, cognitive decline, nausea, vomiting, unresponsiveness and harm to a resident if stopped abruptly. On 09/18/25 at 12:05PM, V6 (Registered Nurse) stated V6 noticed the order for R1's Ativan 1mg tablet three times a day had fallen off the MAR and the remainder of the medication was wasted in the sink with another nurse. V6 stated she should have called the Doctor to ask to continue the medication, but did not call and verify with the Doctor or the Power of Attorney or Guardian. On 9/18/25 at 12:43PM, V7 (Medical Director) stated that he was unaware that R1's Ativan 1mg three times a day was stopped, and the nurse should have contacted V7, as any controlled medication needs to be decreased gradually. V7 stated he talked with the hospital and stated R1 was without the 1mg Ativan three times a day from 9/6/2025 to 9/11/25 which caused her to have withdrawal symptoms. V7 states that any decrease of a controlled substance could cause harm if stopped abruptly without tapering and could lead to seizures, altered mental status, dizziness, syncope, and unresponsiveness. V7 stated from his clinical standpoint that stopping R1's Ativan abruptly caused R1 to become unresponsive and fall, resulting in admission into the hospital. The Facilities Medication Administration Policy Documents that Any changes in medication orders must be documented in the resident's medical record and Medication administration records should be maintained for each resident and must be up to date and easily accessible.