STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056929	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODIN HEALTH AND REHAB CENTER	300 GREEN STREET , ODIN, Illinois, 62870

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S0000	Initial Comments Complaint Investigations: 2555938/IL195599 2555971/IL195603 2556238/IL196008	S0000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1620a) 300.610. Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 300.1210. General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056929	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

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S9999	Continued from page 1 the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 300.1620. Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide narcotic pain medications per physician’s orders for 1 (R1) of 3 residents reviewed for pain management in the sample of 5. This failure resulted in R1 experiencing unrelieved pain and having to be sent to the local hospital for treatment of pain. R1’s “Admission Record” documents that R1 is a 67-year-old that was admitted to the facility on 08/22/2024. Diagnoses included are unspecified fracture of right femur, cirrhosis of liver, pain due to internal orthopedic prosthetic device, pain in right hip, weakness, chronic kidney disease, anemia, and osteoarthritis of right knee. R1’s MDS (Minimum Data Set) dated 06/16/2025, documented that R1 has a BIMS (Brief Interview for	S9999		

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S9999	Continued from page 2 Mental Status) score of 15 indicating R1 is cognitively intact. R1's Care Plan with a revision date of 09/30/2024 has a focus are of "The resident has chronic pain." Interventions listed are "administer analgesia as per orders, anticipate the resident's need for pain relief and respond to any complaint of pain, monitor/record/report to nurse any signs and symptoms of nonverbal pain, monitor / document for probable cause of each pain episode, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past, and monitor / record/ report to Nurse resident complaints of pain or requests for pain treatment. R1's "Order Summary" with a print date of 07/02/2025 document an order for hydrocodone -acetaminophen 7.5 mg – 325 mg by mouth every 4 hours as needed for moderate pain with an order date 06/10/2025 and an order for hydrocodone – acetaminophen 5-325 mg by mouth every 6 hours as needed for pain with an order date of 06/19/2025. Both orders were documented as being "active." R1's June 2025 Medication Administration Record (MAR) documented that R1 received hydrocodone – acetaminophen 7.5 – 325 mg on 06/24/2025 at 12:28 P.M. with a pain level of 7. R1 did not receive another dose until 06/26/2025 at 5:11 P.M. with a documented pain level of 10. There is no charted effectiveness for either date. R1's "Progress Notes" dated 06/25/2025 at 11:20 P.M. document "R1 woke up crying in pain stating her pain level was a 12, currently no pain medication on unit, awaiting refill at pharmacy signed by physician. Requesting to go to local hospital for pain management." R1's "Progress Notes" dated 06/26/2025 at 4:15 A.M. document "Resident back on unit via ambulance company. Paper prescription received for Norco (hydrocodone – acetaminophen) 7.5 mg -325 mg, 8 tablets. Resident in bed stating she was in no pain." The local hospital "ED Provider Note" dated 06/26/2025 1:25 A.M. documented that R1 is at a nursing facility and apparently was controlled with Norco. However, she says that the nursing home ran out this am, and her last dose was 06/25/2025 at 11:00 A.M. She states she feels the pain is due to not being able to take any medications. "I guess patient has pain medication but ran out now has pain, so I guess that is what I am treating, so gave some IM (Intramuscular) fentanyl."	S9999		

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S9999	Continued from page 3 "So, plan to discharge back. Nursing home is asking us to write a prescription for the Norco, I don't have a problem with writing it, but in theory the prescription for narcotics has to be done electronically, and patient has to pick it up. Who picks up the prescription (paper electronic or otherwise) so not sure how the prescription will be honored. I guess it also begs the question, if I can just write a paper prescription for the Norco then why didn't they just call the primary care physician and have her do it? So, I am writing the prescription as a way to help out but its not how the pharmacies usually want a narcotic prescription." R1's June 2025 MAR documented that R1 received hydrocodone – acetaminophen 5–325 mg on 06/29/2025 at 11:41 A.M. with pain level rated at a 10. There is no documentation of R1 receiving another dose until 6/30/25 at 10:00 A.M. with a pain level rated at a 7. R1's "Progress Notes" dated 06/29/2025 at 2:02 P.M. document "Resident is crying due to pain in her right hip and leg. Surgical incisions have no apparent signs / symptoms of infection. Resident is requesting to go to the hospital to get evaluated. Call was placed to physician to make aware and ok'd sending her out for evaluation and treatment as indicated." R1's "Progress Notes" dated 06/29/2025 at 2:15 P.M. document "Resident left the facility per ambulance to go to local hospital. This nurse placed another call to physician regarding having the pharmacy call her for a pain medication refill. Spoke to pharmacy, medication would arrive tonight with the delivery. And a code (to utilize back up supply) be obtained if needed. At 2:26 P.M. this nurse spoke to the local emergency department charge nurse regarding a local prescription that the facility could obtain until the delivery arrives. Pain medications were picked up from local pharmacy by staff." The local hospital "ED Provider Note" dated 06/29/2025 documented that R1 presents to the emergency department for pain management. R1 has been out of Norco for a few days. On 07/02/2025 at 2:51 P.M., R1was alert and orientated to person, place and time, stated she has gone to the hospital twice recently because the facility did not have her pain medication. R1 stated she is not sure why the facility was running out of her medications. R1 stated the ride in the ambulance to the hospital was horrific. R1 stated that she had hip surgery in June. R1 stated that she needs her pain medication because	S9999		

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S9999	Continued from page 4 she can't stand the pain. On 07/09/2025 at 1:15 P.M., V1 (Administrator) stated that she was not notified about R1 having to be sent to the hospital for pain control until after it had occurred. V1 stated there should not be a time that the facility does not have medications for a resident. V1 stated the only way to ensure that the resident received pain medications was to have the emergency department send the prescription to a local pharmacy and have a staff member pick it up. V1 stated that the nurses are to check narcotics in the middle of the week to see if they have any that need refills or a new prescription to prevent residents from running out. On 07/08/2025 at 9:43 A.M., V2 (Director of Nursing) stated when a resident has a script that runs out, the nurse should call the doctor and get a new prescription for the medication. If it is after hours or a weekend, V2 stated the pharmacy can call the doctor on call and obtain the prescription. V2 stated that if the resident has an active prescription for a medication, they can get it out of the backup medication kit. V2 stated that R1 was without her medication and the nurse sent her out twice. V2 stated the resident did have the last prescription filled from a local pharmacy to ensure that she did not have to go back to the emergency department. V2 stated that the prescription was not asked in enough time that R1 would not run out of medications. V2 stated he would expect for the nurses to make sure that a resident does not run out of pain medications. V2 stated now they are looking at the narcotic cards on Wednesday or Thursday of each week to see if anyone needs a refill or a new prescription before the weekend to prevent them from running out of medications. V2 stated on Fridays the nurses are to check to make sure what was ordered came in. On 07/02/2025 at 2:40 P.M., V3 (Registered Nurse) stated the first time that R1 went to the hospital she was sent back with a script for 8 pills. V3 stated that when residents come back from the hospital with scripts, the facility will fax it to the pharmacy. V3 stated she does not know why the pharmacy does not fill the medications when they receive a script. V3 stated the day she sent R1 to the hospital, she was out of medication, and she did not know when the pharmacy would deliver it. V3 stated that she told the hospital that they would get the medication filled at a local pharmacy to ensure that R1 had medication. On 07/09/2025 at 3:13 P.M., V10 (Physician's Nurse) stated that V9 (Physician) wrote a new prescription for R1's hydrocodone on 07/01/2025. V10 stated she has no	S9999		

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S9999	Continued from page 5 documentation of the facility trying to get a prescription before that date. The facility policy titled “Administering Pain Medications” with a revision date of October 2010 documented under general guidelines “1. The pain management program is based on a facility-wide commitment to resident comfort. 2. Pain management is defined as the process of alleviating the resident’s pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Procedure step 6 documents “Administer pain medications as ordered.” (B) Statement of Licensure Violations (2 of 2) 300.610a) 300.1210a) 300.1210b) 300.1620a) 300.610. Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 300.1210. General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:	S9999		

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S9999	Continued from page 6 300.1620. Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure resident received the correct medications in accordance with their physician's orders for 1 (R4) of 3 residents reviewed for medications in the sample of 5. This failure resulted in R4 having increased behaviors and being hospitalized for behaviors. R4's "Admission Record" documents that R4 was admitted to the facility on 08/23/2023. Diagnoses listed are vascular dementia, type 2 diabetes mellitus, brief psychotic disorder, unspecified mood disorder, auditory hallucinations, schizophrenia, anxiety and unspecified psychosis. R4's MDS (Minimum Data Set) dated 03/26/2025, documents R4 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R4 is cognitively intact. R4's Care Plan with a revision date of 5/7/24 documents a "Focus" area of "This resident is on an antipsychotic." Documented interventions include: Administer medication as directed by physician. R4's "Order Listing Report" dated 07/10/2025 documented an order for Haloperidol Decanoate Intramuscular Solution (Haldol) 100 milligram (mg)/milliliter (mL) Inject 1.5 mL intramuscularly every 28 days for agitation related to bipolar disorder with a start date of 06/27/2025 and an order status of "active." R4's "Order Listing Report" documented the same order dated 09/05/2023 with a revision date of 06/27/2025 and an order status of "discontinued.' R4's May 2025 Medication Administration Record (MAR) on 05/14/2025 documented "MN" for the Haloperidol injection. R4's June 2025 MAR on 06/11/2025 documented	S9999		

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S9999	Continued from page 7 “MN” for the Haloperidol injection. The chart code on the MAR documented that “MN” meant medication not available. R4’s “Progress Note” dated 06/01/2025 at 7:27 P.M. documents that R4 became belligerent. R4 threw two books and a remote control at a resident. R4 continued yelling and threatening. R4 shoved her wheelchair at a resident and staff member missing them. R4’s wheelchair hit the medication cart. R4 turned to run back to her room slipping and falling. R4 continued to be belligerent laying on floor. Notified physician of behaviors and received order to send to the hospital. R4 continued making threats to staff including “I want to shoot you in the head.” R4’s “Progress Note” dated 06/02/2025 with a time of 9:10 A.M. documents R4 verbally aggressive towards staff and attempted to hit another resident. While R4 was in her room she placed wheelchair in front of door was screaming and yelling at staff that she would hurt herself and others. R4 sent to the local hospital for evaluation. R4’s “Progress Note” dated 06/02/2025 with a time of 3:48 P.M. documents R4 has been verbally aggressive on multiple occasions, observed swinging her fists at staff and other residents. R4 was kicking the medication cart when nurse tried to go past R4. Attempted to calm multiple times with no change in behavior. While in room, R4 can be heard throwing items and slamming doors. R4’s “Progress Note” dated 06/03/2025 with a time of 9:25 A.M. documents R4 was admitted to behavioral health with diagnosis of aggressive behavior. R4’s “Progress Note” dated 06/18/2025 with a time of 1:50 P.M. documents R4 was threatening suicide with plans to staff, call placed to physician, R4 sent to the local hospital for evaluation and treatment. R4’s “Progress Note” dated 07/02/2025 with a time of 12:36 A.M. documents R4 sitting on side of bed stating she hears voices in her head. R4 pushed her walker against the wall and wheelchair to the other side of the room. R4’s “Progress Note” dated 07/07/2025 with a time of 11:48 P.M. documents attempted to notify physician of missed injections. Message left to return call. The Emergency Department Note from the local hospital	S9999		

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S9999	Continued from page 8 dated 06/02/2025 documented R4 is a 69-year-old female who presents to the emergency department this evening from local facility due to concern for behavioral health issues. Patient does have a known history of dementia and schizophrenia and per report, has been very aggressive toward staff and residents at facility. R4 was seen at our facility a few days ago after sustaining a fall while getting in an altercation with some of the staff and residents they are where she was throwing books at them and trying to hit them with her wheelchair. R4 admits that she has been very verbally aggressive with them as she got really agitated at them. R4 admits that she is hearing voices and says that she has been taking her psych meds regularly. Denies any active suicidal or homicidal plans. R4 was evaluated by our central intake team recommending inpatient voluntary psychiatric admission for unspecified mood disorder. The Behavioral Health Note from the local hospital dated 06/06/25025 documented R4 was admitted voluntarily from local emergency department who presents with worsening depression and with psychosis, inability to keep themselves safe, and inability to keep others safe reports passive homicidal ideation. R4 was monitored in emergency department until medically cleared and transferred to the unit for observation and was placed on suicidal precautions. R4 was provided inpatient psychiatric treatment with Face to Face Interaction, Medication Review & Management, safe and supportive environment, group therapy, individual counseling, behavior management, psychiatric medication, medication adjustment, adverse effect monitor, medical evaluation, medical treatment, social service assessment, resource assessment, and psychoeducation and coordination of care with discharge planning. The Emergency Department Note from the local hospital dated 06/19/2025 documented R4 presents with signs and symptoms of depression, anxiety, psychosis, bipolar disorder, schizophrenia, and neurocognitive disorder which include psychosis and inability to keep themselves safe in the context of psychosocial stressors. R4 meets criteria for inpatient hospitalization with capacity to make medical decisions and is observed a danger to self and/or unable to care for self-requiring inpatient psychiatric hospitalization for stabilization and coordination of care. Expected length of stay 5-7 days. On 07/09/2025 at 1:15 P.M. V1 (Administrator) stated she has no idea why R4 did not get the Haldol that was ordered in May 2025 and June 2025. V1 stated	S9999		

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S9999	Continued from page 9 that would be a question for V2 (Director of Nursing). V1 stated that it is her expectation that residents in the facility receive the medication that the doctor orders when it is due. On 07/09/2025 at 1:37 P.M. V2 (Director of Nursing) stated he is not sure why R4 was not given her Haldol when it was ordered. V2 stated that he was not aware until today that it was a problem. V2 stated that he reviewed the medication cart and there are vials of Haldol with R4's name on it. V2 stated that it is his expectation that the nurses give the medication that the doctor orders. V2 stated that the Medication Administration Record documents that the medication was not given, and the nurse should have notified the physician and followed up on it. On 07/08/2025 at 9:33 A.M. V4 (Certified Nurse Assistant) stated that she was told by other staff that R4 was off her medication and that is why she had been having an increase in behaviors. V4 stated she is not sure if the doctor had discontinued a medication or if she had run out and they were waiting on the pharmacy to deliver it. V4 stated that R4 has been better since she came back from the hospital the last time. V4 stated she is not sure if there was a medication change or if she was back on what she was supposed to be on. On 07/08/2025 at 9:37 A.M. V5 (Registered Nurse) stated she does not remember R4 ever running out of her medications. V5 stated that if a resident is out of medications, she will attempt to get it out of the backup pharmacy. On 07/08/2025 at 3:52 P.M. V6 (Family Member) stated that she can tell when R4 is not receiving her medications correctly. V6 stated that R4 has not been stable in a couple of months. V6 stated that R4 had a break down and was sent to a local hospital for treatment last month due to her behaviors. V6 stated she has tried to ask the facility and the pharmacy about R4's medication but she feels she is getting the run around and no real answers. V6 stated that she thinks that R4 has not received her Haldol injections because the medication was not on the bills she has received. V6 stated that when R4 is off her medications, she gets hateful, and rude. V6 stated that if R4 was receiving her Haldol she would not be having the hallucinations. V6 stated that R4 has been on Haldol for the last 15 years. V6 stated the only time that R4 hears voices id because she is not receiving her medications. V6 stated that R4's admission to the hospital in May she feels is related to her not receiving her medications as she is supposed to. V6	S9999		

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S9999	Continued from page 10 stated that a certified nurse assistant from the facility told V6 that she does not think R4 is getting her medication like she is supposed to. On 07/08/2025 at 9:23 A.M. R4 stated that there has been trouble getting the medications that she is supposed to take. R4 stated she does not remember the last time she received her Haldol injection. The facility policy titled “Medication Administration Policy / Procedure” with a revision date of 09/27/2022 documented “Medications will be administered safely to residents within the facility by licensed nurses at the specified time / timeframe, following the recommended administration method and will be documented as required.” (A)	S9999		