STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145649	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odin Health and Rehab Center	300 Green Street Odin, IL 62870

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure residents were free from sexual abuse for 3 of 3 (R2, R9, R11) residents reviewed for abuse in the sample of 34. This failure occurred on [DATE] when V4 (Physician/Co-Medical Director) asked to see and touch R9's genitalia (inappropriate word for female genitalia), while R9 was sitting in the lobby of the facility near the front doors. R9 stated this had been going on for a few months, she would get upset by V4's behavior, her anxiety would rise before he was scheduled to visit, and she began wondering if she had said something to initiate this behavior and began blaming herself. R9 stated she was afraid to tell anyone because it would be her word against his and no one would believe her. The Immediate Jeopardy began on [DATE] when V4 was witnessed by this surveyor making inappropriate sexual comments to R9. V1 (Administrator), V53 (Chief Clinical Officer), and V54 (Resident Services-Corporate) were notified of the Immediate Jeopardy on [DATE] at 4:20 PM. The surveyors confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE] but noncompliance remains at Level Two due to additional time needed to evaluate the implementation and effectiveness of in-service training. Findings Include: 1. On [DATE] at 12:50 PM, this surveyor was sitting in the beauty shop waiting on a staff member to interview. This surveyor heard a male voice and a female voice start a conversation. They were not in the line of sight of this surveyor but were close enough to the beauty shop to hear their conversation. He asked if she was leaving. She told the man no she was just sitting. The conversation continued between the male and female voice and then the male voice asked her if he could see her pu**y and then asked if he could touch her pu**y. This surveyor stepped to the door and both the woman (later identified by staff as R9), and the man identified by this surveyor as V4 (Physician/Co-Medical Director) were there. R9 was sitting on a seat located just outside the beauty shop door and near the front doors of the facility. V4 was standing in front of R9. V4 exited the facility and this surveyor sat down next to R9, after asking V37 (RN/ Registered Nurse) who was coming for an interview to wait just a minute. This surveyor asked R9 if she knew who the man was and she said he was the doctor who comes to the facility. This surveyor asked R9 if V4 said something unusual to her and she said, Oh, that is just how he is, and shrugged her shoulders. On [DATE] at 12:51 PM, V37 (RN) identified the resident sitting in the lobby speaking with V4 as R9. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:15 PM, R9 agreed to speak with this surveyor and wanted to talk in the beauty shop. This surveyor asked R9 if V4 had said something inappropriate to her. R9 stated he had and that he had done it before. This surveyor asked R9 if we could get a staff member to speak with us and she agreed. V2 (DON/Director of Nurses) was the first staff member this surveyor located in the conference room. V2 went with this surveyor to the beauty shop where R9 was waiting. This surveyor informed V2 this surveyor heard V4 say something inappropriate to R9. R9 told V2 that V4 had asked to touch her breasts and vagina and had been asking it for several months. R9 told V2 she thought V4 was joking at first but that it had gotten worse. V2 left with R9 to report the allegation to V1 (Administrator). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Verification of Incident Investigation/Administrative Summary date of incident [DATE], documents under Brief description of the incident/event: An allegation was made by the (state survey agency) surveyor that she overheard V4 (Physician/Co-Medical Director) make an inappropriate sexual comment to resident (R9). Administrator notified and investigation immediately initiated. (V4) exited the facility immediately after alleged incident and then was informed by staff that he could not return to facility pending outcome of investigation .Resident has been observed, assessed and/or interviewed, showing potential effects related to allegation. Such affects have been addressed and care plan has been updated A comprehensive investigation was initiated on [DATE]. (State survey agency) surveyor alleged that (V4) asked resident (R9) if he could see her pu**y. Upon interviewing (name of state surveyor) she stated that she heard (V4) state that but did not hear if R9 said anything prior to that. (State Surveyor) was unsure of general conversation or what was said in between or what had been said prior to that. (State Surveyor) stated she observed (V4) in front of (R9) but there was no contact observed by (State Surveyor). (R9) stated in her interview that (V4) asked to see her breasts and vagina. (R9) said that it had been going on a couple of months and she had never told anyone. (R9) denies saying anything sexual to (V4) on [DATE]. (V4) was interviewed and stated as he was leaving the facility (R9) was near the front door and asked him if he wanted to touch her tits and pu**y. (V4) stated he repeated to her what she said for clarification and then he advised (R9) that he absolutely did not want to touch her and never would do so. Interview with V48 (MDS Coordinator, RN/Registered Nurse) in which she stated that there have been several times where (V4) stated to (V48) that he would not go to (R9's) room without someone with him as she often comes off as inappropriate in a sexual manner, speaks of multiple boyfriends while attempting to display herself flirtatiously. Review of records note on visit on [DATE] that (V4) notes in his medical visit with (R9) that she tends to flirt with all the males and that is not a secret. She tells you that. She says she has many boyfriends. Also noted, She flirts with all the men and does show them dirty pictures on telephone and that is the first I knew about it today. Residents interviewed denied (V4) had said anything inappropriate and had no concerns with his care. Staff interviewed had not witnessed (V4) say anything inappropriate to residents but had been witness to (V4) stating he did not want to go into (R9's) room by himself due to her inappropriate behavior. The facility does not substantiate the allegation as (V4) stated he was repeating what she said and that (R9) propositioned him. There are notes of (R9's) behavior noted in previous MD (physician) progress note on ,d+[DATE] and staff have also heard (V4) express concern of going by himself due to her flirtatious behavior prior to this allegation. The residents and staff have not had any concerns with (V4's) care. (R9) denies he stated the word pu**y, and her account is not the same as what was reported. (R9) remains at baseline and has had no negative psychosocial outcome .Follow-Up Actions Taken: Trauma Assessment completed. Abuse assessment completed. Discussed the choice of changing attending Physician with resident and decision was made by resident to change. Psychosocial assessment and follow up in progress. Care plan was reviewed and updated by IDT (Interdisciplinary Team). (V4) is assisted on rounds for all residents and will continue to be assisted by a licensed nurse while in the building. There is an x next to Responsible Party, Attending Physician, (name of survey agency)/Licensing and Certification, Ombudsman, Local Police Department; indicating they were notified of the allegation with no dates or times of notifications documented. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10: 20 AM, R9 was interviewed and was found to be alert and oriented times three. R9 denied hallucinations, delusions, and paranoia. When asked if she had anxiety R9 stated, depends. When under stress, it goes up a lot. R9 stated V4 had been her primary care physician since she was admitted to the facility. R9 stated at no time during her interactions with V4 did he appear confused or disoriented. R9 stated V4 sees her a lot, he is here about every week or every other week. R9 stated she felt like she was getting good care from V4 and there was nothing unusual in his interactions with her until a few months ago. R9 stated that is when V4 started telling her, You are pretty, and asking, Do you have a boyfriend. R9 stated, I felt at first like he was trying to make me feel good and raise my spirits. But then he started saying, I have never seen you naked, maybe I need to. R9 stated, He (V4) did not say that (he needed to see me naked), and then give me a physical exam and I did not believe he was talking about giving me an exam. I felt like he was suggesting something sexual. I felt like his behavior was inappropriate for a doctor. I told him there was no reason to see me naked and I told him if I did need a physical exam, I would have another doctor do it, not him. R9 stated, V4 began to get worse with his comments, saying he wanted to play with my pu**y and breasts. R9 stated she previously stated V4 used the word vagina but the actual word he used was pu**y but she was ashamed to say that word. R9 stated, I told him he was going too far in saying things like that and he would laugh and act like it was a joke. R9 stated she would get upset by V4's behavior and her anxiety would rise before he was scheduled to visit wondering, what will he say or do today? R9 stated she began wondering if she had said something to initiate this behavior and blamed herself. R9 stated he had never actually touched her except to take her pulse. R9 stated V4 did not threaten her not to tell, but he told her, This conversation is between us, its personal, not professional. R9 stated she was afraid if she told staff, it would be her word against his and nobody would believe her. R9 stated, I just wanted to try to handle it by myself. R9 stated V4 never said anything inappropriate in front of staff, and usually staff were with him. R9 stated after V4 was done seeing everyone he would, sneak back into my room when they weren't looking. R9 said she was glad the surveyor heard what V4 said so that now he will stop. R9 stated staff called her in the office after the surveyor reported what she heard and questioned her about it and had a bunch of papers she had to sign. R9 stated she felt like staff felt as though I had led him on in some way, although nobody actually said that. R9 stated staff did not tell her they reported it to the police and the police had not contacted her. R9 stated she would not be comfortable with V4 as her physician and the facility had told her they would get her another physician. R9 stated R11 is a younger resident and she had asked R11 if she had ever experienced V4 saying or doing anything inappropriate to her and R11 stated V4 had been telling R11 she was pretty. On [DATE] at 1:45pm, V52 (Family Member) stated, on [DATE] or [DATE], She (R9) told me that her physician (V4) made inappropriate comments to her. She (R9) said she was sitting out in the front lobby area by the entrance, and he (V4) was leaving, and he (V4) said something to the effect of 'I want to see your boobs and vagina and touch your body.' V52 stated mom is friendly and told V52 that she was worried that by being friendly she somehow brought his behavior on. V52 stated she told R9 his (V4) conduct was inappropriate and she had not done anything to cause it and it was not her fault. V52 stated this was the first time R9 said anything about him acting that way. V52 stated she didn't think R9 had any residual effects from the incident aside from being somewhat stressed out about it. V52 stated she didn't think R9 understood the severity of what he did until the surveyor heard it and came out and asked her about it. V52 stated R9 had no history of sexually inappropriate behaviors. V52 stated R9 has no history of making up allegations against staff. V52 stated she believed her mom as there is no reason not to. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:13 PM, when asked if he could describe what happened with R9 on [DATE], V4 ((Physician/Co-Medical Director)) stated, R9 always propositions him. V4 stated it was not the first time. V4 stated he said, absolutely no and walked out the door that day. When asked if he recalled the conversation, he had with her that day in the lobby he said she was asking him to touch her. V4 stated he could not really remember what was said but something like that. V4 stated that R9 was always flirting. V4 stated R9 was always asking him to touch her. V4 stated he would tell her to go away, and she would come up and flirt. V4 stated most of the time it happened in the cafeteria. V4 stated when he would see residents someone (staff) was with him but that didn't matter to R9, she would find him. V4 stated he didn't think R9 was cognitively with it. V4 stated the facility reported she had alcoholic dementia. When asked how many times R9's behaviors occurred, V4 stated in excess of 10 times. V4 stated it was documented in R9's progress notes. When asked if he could recall the dates of those notes, V4 stated no that is what the facility told him. V4 stated he wasn't sure how long he had been R9's doctor but it had been maybe a few years. V4 stated he was not her doctor prior to R9 coming to the facility. V4 stated he only sees residents in nursing homes. V4 stated the last word he said to R9 was absolutely no, and has not seen her since. V4 stated he wasn't sure if he was still R9's doctor. On [DATE] at 2:05 PM, R22 stated none of the female residents have made inappropriate sexual comments to him, nor shown him inappropriate material. R22 stated R9 told him, a couple of weeks ago, that she was upset because she was having problems with her doctor saying things to her he shouldn't say, saying he wanted to see her naked or to see her t**ties or something like that. R22 stated he told R9 she needed to tell somebody, but she didn't want to. R22 stated, from what I've heard he's (V4) a big flirt. On [DATE] at 10:00 AM, V3 (CNA/Certified Nursing Assistant) stated the last abuse in-service they had was maybe a couple of weeks ago, she's not sure. V3 stated she had never witnessed R9 being provocative or sexually inappropriate with any male staff or residents. V3 stated she had never seen R9 dress inappropriately. On [DATE] at 10:05 AM, V56 (CNA) stated the last abuse training they had was this past Friday. V56 stated she had never witnessed R9 being inappropriate or sexually inappropriate with male staff or residents, nor dressing suggestively. On [DATE] at 10:10am, V57 (CNA) stated they went around with a training for the staff to read and a sign in sheet about abuse within the past week. V57 stated she had seen R9 showing male residents' stuff on her phone, but hadn't seen what they were looking at, so she can't say whether it was sexual in nature. V57 stated she had not seen any inappropriate sexual behavior on her part toward staff or residents. V57 stated she had not witnessed R9 dress inappropriately. R9's Admission Record with a print date of [DATE], documents R9 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anemia, alcoholic hepatitis. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R9's MDS (Minimum Data Set) dated [DATE] documents R9 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R9 is cognitively intact. This same MDS documents under Mood that R9 is assessed as having little interest or pleasure in doing things, feeling down and depressed, trouble falling and staying asleep, and feeling bad about yourself- or that you are a failure or have let yourself or your family down. This same MDS documents R9 has no behaviors, and no potential indicators of psychosis. R9's current Care Plan documents a Focus Area of (R9) displays attention seeking behaviors which can be disruptive, insensitive and/or disrespectful to staff and peers. [NAME] (sic) for immediate gratification. Date Initiated: [DATE] . Interventions for this care area initiation date of [DATE] include, Assure the resident that staff are more than willing to address legitimate concerns .Educate resident on appropriate means of requesting help for self or others .If the residents use We statements intervene by saying Please speak for yourself. Please use 'I.' Tell me what YOU want. Let other residents speak for themselves. Inform the resident that he/she may share his thoughts, needs and feelings with on (sic) identified staff member .Psych eval and tx (treatment) as necessary Remind resident that if emergent situation exists, staff will call 911 as appropriate .Set Limits . R9's Care Plan documents a Focus Area of Anxiety: As manifested by Situational anxiety. Date Initiated: [DATE], Created on: [DATE]. This Focus Area documents interventions dated [DATE] that include, Anti-anxiety medication as ordered .Encourage resident to identify and express causes of anxiety .Encourage to participate and discuss personal care . There is no Focus Area for sexually inappropriate behaviors documented in R9's Care Plan. R9's Abuse Risk assessment dated [DATE] documents the following risk factors were identified; history of chemical or substance abuse, persistent anger, fear, or anxiety, diagnosis of dementia, history of unsanitary living conditions, and attention seeking behaviors. R9's Behavior Monitoring and Interventions Report dated [DATE] documents, No results found for selected parameters. R9's Physician/Order Progress notes signed by V4 (Physician/Co-Medical Director) document the following: [DATE]- Purpose of Visit: This lady is back to normal, totally cognitively intact. Takes care of all activities of daily living. I forget why she is here, but the examination is totally, totally normal. I am asking (V48) MDS/Care Plan Coordinator, who knows her well, how much of this is related to alcohol? Probably a lot but we are unsure. She is getting ready to go back home and that I hope is not a problem. There is no documentation of inappropriate sexual behavior on this physician progress note. [DATE]- Purpose of Visit: She takes care of all activities of daily living. She is getting ready to go home is what I have said before, but she is not home. She appears to have some cognitive impairment but what can she do for herself? Everything. Physical exam, review of systems, laboratory, medication. Now we are not sure about her going home. I looked at medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]- Purpose of Visit: toxic encephalopathy, malnutrition, alcoholic hepatitis without ascites, difficulty walking, altered mental status. She is back to normal. 15 out of 15 MMSE (Mini Mental State Examination) I watched her walk So, she has all of the above problems, now solved so to speak . She specifically is on no psychotropic . This physician progress note does not document any sexually inappropriate behaviors. [DATE]- Purpose of Visit: she was admitted actually with toxic encephalopathy, alcoholic hepatitis without ascites, malnutrition, difficulty walking, altered mental status. Her cognition returned to pretty well normal. This toxic encephalopathy was apparently related to alcohol. She is up and about, taking care of all activities of daily living, telling me she can fry chicken real well because she ran a golf course restaurant which specialized in barbeque, and I am sure this is true. Actually, the heart, lungs, and abdomen negative. She will be going according to the daughter to an assisted living, so most of these have been resolved I want to make sure I have her on vitamin D. I looked at all the medicine she is on, and she is on appropriate vitamin D. I do not really see anything that we need to discontinue. Now, the question is when she goes home, will she start drinking again, an unanswerable question. Of course, when she goes to assisted living, it might a (sic) little more difficult to get. There is no documentation of inappropriate sexual behavior on this physician progress note. [DATE]- Purpose of Visit: She was admitted with inability to care for self. I am seeing her for routine care plus a itchy dry place anterior aspect of the right lower leg just above the ankle. She has obviously been scratching it because of scratch marks. She says she is not. I think this is dry skin. I asked (V48), care plan coordinator, has she cleared cognitively since admission. Yes, dramatically. She does everything by herself. She is ready for discharge but there is no home for her. I say that because she was admitted with toxic encephalopathy, alcoholic hepatitis, ascites, malnutrition, altered mental status, difficulty walking. This appears, as I have said before, quite normal. I watched her walk. She had normal gait and balance. Used a wheeled walker. Is not falling. Review of systems totally negative. I looked at many blood pressures, pulses-they are all normal. She is doing not well, very well. She is on vitamin D, Artificial Tears, Dulcolax, Iron, folic acid, loratadine, Milk of Mag, omeprazole, Tylenol, B1, zonisamide. There is no documentation of inappropriate sexual behavior on this physician progress note. [DATE]- Purpose of Visit: She is homeless. She has a daughter who just had a baby, and she tends to flirt with all the males and that is not a secret. She tells you that. She says she has many boyfriends, but I am seeing her for routine required evaluation. She has a history of toxic encephalopathy apparently due to excessive alcohol. I have talked about that before. But actually, she does everything herself; feeds, clothes, bathes herself. Does she have any problems: I do not think so. She flirts with all the mean (sic) and does show them dirty pictures on her telephone, and that is the first I knew about it was today. She has actually recovered it appeared form alcoholic encephalopathy but the heart, the lungs, the abdomen negative. She wants nothing. And she will probably be a permanent resident here. Her vital signs look good. Heart, lungs, abdomen as stated negative. She has been to behavioral health at (name of regional hospital). They said she had dementia with aggressive behavior. I do not see that, and she certainly does not have aggressive behavior. Inappropriate behavior. She is on very minimal medication. She is on iron with no recent laboratory. [DATE]- handwritten note that documents, stable, history of alcohol, cares for self, homeless. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]- handwritten note that documents, Needs to go home, oriented x (times) 4, exam all ok, Ok to go home. [DATE]- handwritten note that documents, Does everything, Dx alcoholic encephalopathy . [DATE]-handwritten note that documents, Can care for self- can live alone Past diagnosis alcoholic dementia now BIMS 15 Ok to DC (discharge). I told her return if she wish. There is no documentation of inappropriate sexual behavior on the physician progress notes dated [DATE], [DATE], [DATE], and/or [DATE]. R9's Progress notes from [DATE] to [DATE] contain no documentation of inappropriate sexual behavior, boyfriends, or sharing inappropriate material with anyone. R9's progress notes document a late entry dated [DATE] that documents, Alleged allegation of inappropriate statements made to resident from physician. Resident was taken to a safe area, surveyor reported to DON (V2), DON (V2) reported to ADMIN (administrator/V1), confirmed resident was safe, and physician was immediately suspended from facility until further notice of investigation and findings. R9's Progress Notes document continue to document the following [DATE], Spoke to resident in regards to her MD (physician). Resident stated she would like to have a different MD that is in the (name of town) area for when she discharges to home. Physicians in (name of town) reviewed. Resident did decide she would like to use (name of physician) as her facility physician. MD contacted and did accept. [DATE] 7:37 PM, Spoke to V4 and advised that facility had completed investigation and allegations are unfounded at facility level. Furthermore, advised V4 facility continues to await response from (State Survey Agency). R9's electronic medical record including care plan, progress notes, behavior tracking, and tasks do not document any behaviors including sexually inappropriate behaviors were being tracked and/or occurred. 2. On [DATE] at 3:15 PM, R11 stated V4 is her primary care physician, and he sees her about once per month. R11 stated R9 told her a few days ago that she was sitting in the front lobby area when V4, Talked to her bad, he said he wanted to play with her breasts and finger her vagina. R11 stated A bunch of us residents have talked about V4 being a big flirt. R11 identified R2 a resident who passed away and R31 a resident who moved as being some of the residents who discussed V4 being a flirt. R11 stated V4 would say to them, You're a pretty woman, what are you doing in here? R11 stated, R2 and R31 interpreted that as him trying to lift their spirits. R11 stated V4 had also told her she was pretty. R11 stated, a few months ago he told me his wife had died and in the same conversation he told me he was going to write me a prescription for a boyfriend, and I felt like he was hinting for a date. R11 stated, The last visit I had with him, not sure what the date was. I was uncomfortable, he started talking about his car, how fast it goes, what a good deal he got on it, how nice it is, and I thought, is this [NAME] trying to ask me for a date? R11 stated V4 had never touched her inappropriately and staff were always with him in her room. R11 stated she believed R9 when she told her about her encounter with V4. R11 stated she had known R9 pretty well for a while now and from what she had seen R9 is not the type of person to make stuff up or be dramatic to get attention. When asked how she felt about continuing to have V4 as her physician, R11 stated, I never wanted him in the first place, everybody knows he's a quack. I asked him why my legs swell up and he said, it's because your fat. On [DATE] at 9:40 AM, R31 denied concerns with V4. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R11's Resident Information sheet with a print date of [DATE] documents R11 was admitted to the facility on [DATE] with diagnoses that include malignant neoplasm of long bones, diabetes, asthma, morbid obesity, hypertension, mass and lump right lower limb, sleep apnea, major depressive disorder, adjustment disorder with anxiety, post-traumatic stress disorder, anxiety disorder, panic disorder, malingering, chronic cluster headache, leiomyoma of uterus, and bone transplant. R11's current Care Plan documents a Focus Area of This resident has the potential for abuse/neglect r/t (related to) Depression diagnosis, psychiatric diagnosis or manifestation, including delusions, paranoia, and hallucinations, Underlying factors that increase vulnerability; including such as dementia, confusion, poor judgement, wandering and giving away personal property. The interventions for this Focus Area include assess coping skills and support system, consult psychiatry as indicated, encourage to discuss feelings, give choices regarding personal care, monitor/documents any signs/symptoms of potential self-harm or harm directed at others, notify physician of any at risk behavior, perform risk assessments as needed, set limits to ensure safety. R11's diagnoses listed in her record do not include a diagnosis of dementia. R11's behavior tracking sheet for April and [DATE] documents no behaviors were observed. R11's progress notes document the following [DATE] 5:18 PM, Resident involved in allegation of abuse. [DATE] 5:20 PM, Call placed to V4 to advise him that he would not be able to come to building as resident has made an allegation that V4 made her uncomfortable during a visit and she feels that he wants a date with her. V4 expressed understanding that he cannot come to facility at this time. [DATE] 5:47 PM, (name of officer) Badge number 45 was at the facility and did interview resident. (Name of officer) did come to my office and notify me that resident did refuse to write a statement. (Name of officer) did question resident in regard to accusation and resident denied any sexual verbal comments from V4. (Name of officer) notified me that he would make a statement if needed and I could stop by the (name of local police) for a copy this week. Will follow up this week to obtain a copy. The Dispatched Event Details (police report) documents on [DATE] at 5:50 PM, V2 (DON) called and reported an allegation of verbal sexual abuse. Under Supplemental Event Notes the report documents, .On [DATE] at approx. (approximately) 6PM, I was dispatched to (name of facility). Upon arrival, I met with the Director (V2/DON). She explained that 2 of the residents had made allegations that a Dr (doctor) had made sexual advances to them. I went and talked to the first one, (R11). I asked what had happened, she said the Dr. had joked around with her but had never said any thing sexual in nature to her. She said he had said some things that made her uncomfortable but nothing sexual. I asked her to write a statement and she declined to make a statement. I then talked to (R9) she said the Dr. had asked to see her breasts and vagina. I asked what she said, and she said she didn't say anything and that there was a state inspector that overheard him say it. I then had her write a statement. 3. R2's Admission Record with a print date of [DATE] documents R2 was admitted to the facility on [DATE] with diagnoses that include osteomyelitis, diabetes, malignant neoplasm of colon, morbid obesity, and peripheral vascular disease. R2's MDS dated [DATE] documents R2 is independent with decision making. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Progress Notes dated [DATE] document, .Resident (R2) was taken to an appointment with (name of physician), her O2 sats were down and they were unable to get them up therefore resident was sent to the ER (emergency room) at (name of regional hospital). On [DATE] at 12:37 PM, V3 (Family Member) stated R2 passed away at the hospital on [DATE]. On [DATE] at 9:20 AM, V32 (Family Member) stated R2's physician (V4) made a comment to R2 one time when she had something wrong with her bladder. V32 stated V4 told R2 that she needed more sex. The facility Abuse Policy dated [DATE] documents, Purpose: To provide guidance and Procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Responsibility: the administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staff responsibility (sic) report any allegation or witnessed abuse immediately to the Administrator (Abuse Coordinator). Abuse Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Procedure: conducting pre-employment screening of employees and pre-admission screening of residents, orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property. Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. Identifying occurrences and patterns of potential mistreatment, identifying concerns of residents allegations of deprivation of goods and services by staff, immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure residents assessed as being a high risk for elopement were adequately supervised and then failed to identify this same resident as an elopement risk after an elopement for 1 of 3 (R1) residents reviewed for accidents and supervision in the sample of 34. This failure resulted in R1, who had a history of confusion and was assessed as being a high risk for elopement, exiting the facility without staff knowledge, at an unknown time, walking 4.4 miles to a neighboring town along a busy highway where he was located by facility staff at 7:00 AM on 4/13/24. The Immediate Jeopardy began on 4/13/24 when R1 exited the facility without staff knowledge. R1 walked approximately 4.4 miles and was found by facility staff at 7:00 AM on 4/13/24. V1 (Administrator) was notified of the Immediate Jeopardy on 4/29/24 at 1:57 PM. The surveyors confirmed by observations, interview, and record review that the Immediate Jeopardy was removed on 4/13/24, but noncompliance remains at Level Two due to additional time needed to evaluate the implementation and effectiveness of in-service training. Findings Include: 1. R1's Admission Record with a print date of 4/16/24 documents R1 was admitted to the facility on [DATE] with diagnoses that included disorders of circulatory system, diabetes with hyperglycemia, hypertension, hypercholesterolemia, atrial fibrillation, and tobacco use. R1's MDS (Minimum Data Set) dated 2/6/24 documents a BIMS (Brief Interview for Mental Status) score of 14, which indicates R1 is cognitively intact. R1's hospital records dated 1/29/24 documents R1 was taken to the local emergency room by a friend and stated R1 was more confused than normal. Pt (patient) alert to person and place only. Disoriented to time. Pt is currently homeless and has been staying with friends. They are trying to get patient into (name of homeless shelter) Patient has been approved but they cannot accept him until tomorrow at 1:30 for intake .Pt states he has a home, but no running water or electricity. Suggested that pt return to his home for tonight as temperatures are not below freezing and go to (homeless shelter) tomorrow for intake R1's hospital records document under neurological assessments R1 is alert and oriented to person, place, and time. R1's hospital records dated 1/30/24 documents on 1/30/24 at 2:57 PM, (R1) .with a past medical history that includes- DMII (diabetes mellitus), HLD (hyperlipidemia), HTN (hypertension), MRSA (methicillin resistant staphylococcus aureus) abscess, a-fib (atrial fibrillation) RVR (Rapid Ventricular Response), DKA (diabetic ketoacidosis) ---presents to the ER (emergency room) c/o (complaints of) being found walking through town and had soiled himself. Was going to be intake to (name of homeless shelter) today, but they canot (sic) take a dementia resident. He is asking to go to a SNF (Skilled Nursing Facility). The hospital record documents under Medical Decision Making .Details: Adult protective services caseworker (V46). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/30/24 at 11:18 AM, V46 (Adult Protective Services) stated that on 1/29/24 R1 was evaluated at the emergency room (ER) and was discharged . V46 stated R1 was supposed to go to a homeless shelter but either had forgotten or didn't call them. V46 stated R1 was found by friends wandering outside in the cold. V46 stated R1 was covered in feces and urine and had gotten frost bite. V46 stated R1 didn't recognize his friends so they contacted the police who contacted V46 on 1/30/24. V46 stated R1 was taken back to the hospital, and she felt like R1 needed placement in a long-term care facility. V46 stated she spoke with the ER physician, and he agreed. V46 stated after R1 was admitted to the facility on [DATE], she followed up with him at the facility. V46 stated she could recall the specific day but at that time R1 looked good, he was clean, and had friends at the facility. V46 stated she closed out R1's case since he was in the facility. V46 stated when she would see R1 he would not remember her, and she would have to remind him who she was. When asked if she would consider R1 safe to come and go independently from the facility, V46 stated, she would say so, but her concern would be R1 getting linked up with someone who would take advantage of him. V46 stated that is what happened with his home and stuff. R1's regional hospital Progress Notes dated 1/30/24 documents, SW (Social Work) informed that patient is in ED (Emergency Department) and requesting nursing home placement. Per chart, patient was accepted to homeless shelter yesterday, but they could not accept until today. Patient was found today by friend confused and wondering the streets. SW met with patient who confirms would like nursing home placement Patient states would prefer to stay in (name of town) but is agreeable to whatever facility can accept him at this time (Name of facility currently residing in) has accepted. Nurse updated patient. Facility to transport On 5/1/24 at 4:06 PM, V55 (Director of Social Service Regional Hospital) stated R1 was evaluated at the emergency roiagnom on [DATE] and was accepted by a local homeless shelter, but they didn't have an opening until the next day. V55 stated R1 had a home but it had no running water. V55 stated R1 was going to stay at his home that night and then go to the homeless shelter the next day. V55 stated R1 came back to the hospital the next day. V55 stated a different social worker saw R1 and his mentation had gotten worse so they decided it would be better for R1 to be placed in a nursing home. V55 stated R1 got really confused. V55 stated the physician didn't say he was confused it was the social workers assessment. R1's current Care Plan documents a Focus area of Potential Risk of Elopement-Exit seeking behavior Date Initiated 3/22/24. This Focus area documents the following interventions dated 3/22/24, Place Electronic Sensor device to alert staff of exit attempt (or if unavailable, place on 1:1 observation) Routinely check device placement, check battery function, eval (evaluate) effectiveness .Identify any patterns or exacerbating factors .Maintain adequate I.D. (identification) .Monitor residents interactions with peers to identify escalating tension, frustration or aggression; Intervene .Monitor whereabouts regularly; Recognize any unsafe condition or escalating patterns .Provide redirection and diversion as needed .Respond to any alarm activation promptly .try to identify reasons when possible. Address physical needs such as hunger, thirst, pain, toileting, hot/cold, emotional needs, fear/distress, loneliness, worry . R1's Elopement Risk Assessments dated 3/8/24 documents a score of 02, indicating R1 is not at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Progress Notes document on 3/22/24 at 8:02 PM, alarm sounding to side area yard that is fenced in. Nurse immediately went to alarm outside and found resident confused holding the fence on the inside of the yard, not leaving the premises. Head to toe assessment completed with no injuries noted to resident. Resident was immediately redirected to inside the building without any aggression or hesitation. Wander-guard was immediately placed on resident left ankle with 2 finger breadths noted. Resident placed on 15 minutes checks related to safety. MD (physician) and emergency contact notified with no concerns voiced at this time. Nursing management notified, and MDS notified for care-plan placement. R1's Order Recap Report dated 3/24/24 to 5/31/24 includes the following orders, Place wanderguard on resident for safety r/t (related to) exit seeking behaviors,. Wanderguard check function Q (every) weekday shift every Fri (Friday) for Wandering, Wanderguard - Check placement every shift for monitoring, all have a start date of 3/22/24. R1's Community Safety Awareness Summary dated 3/22/24 documents a handwritten assessment that documents R1's prior living arrangements as homeless, that he lived alone and came to the facility for medical condition of frostbite. R1 is documented as having secondary comorbidities that include diabetes with no history of substance or alcohol abuse. The assessment documents R1 is alert and oriented to person, place, and time and makes decisions independently. This assessment documents R1 doesn't have difficulty focusing attention, is not easily distracted, doesn't have difficulty keeping track of what is said and is not on any antidepressants, antianxiety, sedative hypnotics, narcotic pain medications, or psychotropics. This assessment documents R1 is safe to ambulate independently and can cross a street independently with or without a light. It documents no potential risks and that R1 is safe to leave the facility on pass. This assessment is signed by V1 (Administrator), V2 (DON), V48 (MDS Coordinator) and V28 (Social Services Director). On 4/30/24 at 3:56 PM, V1 (Administrator) stated the Community Risk assessment dated [DATE] was signed by V2 (DON/Director of Nursing), V48 (MDS Coordinator), and V28 (Social Services Director/SSD). V1 stated they were all at the facility doing the assessment. When asked if she remembered what time it was done, V1 stated it was done early, sometime in the morning. R1's Documentation Survey Report VT2 dated March 2024 documents a behavior of wandering on 3/22/24 evening shift. The next Elopement Risk Assessment for R1 found in the record was dated 4/3/24 and documents a score of 18, which indicates R1 is at high risk of elopement. On 4/19/24 at 10:52 PM, V22 (Anonymous) stated on 3/22/24 R1 was outside and attempting to leave the grounds, and she convinced him to stay because it was cold outside. V22 stated R1 thought he was in a different town and didn't know he was in the town the facility is located in. V22 stated R1 did not have any health issues that would have caused the confusion. On 4/24/24 at 1:49 PM, this surveyor reviewed R1's 3/22/24 progress note and asked V2 (DON/Director of Nursing) if there were alarms on the outside gate. V2 stated there were not. V2 stated she didn't know if she was contacted related to the incident on 3/22/24 that she would have to check into what this surveyor was talking about. This surveyor reviewed the progress note again with V2 and asked if that helped her remember. V2 stated R1 is not a high risk for elopement. When asked if she was aware R1 had been assessed as being at high risk for elopement V2 stated if it was at night, then no. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/24/24 at 3:24 PM, this surveyor reviewed with V1 (Administrator) R1's 3/22/4 progress note where R1 was outside leaning on the fence, confused, and was assessed as being at risk for elopement. V1 stated she didn't know what else was going on that night and V4 (Physician/Co-Medical Director) said he was doing it as a safety measure. V1 stated V4 (Physician) saw R1 prior to him being at the facility. When asked if she knew what happened on 3/22/24, V1 stated she read the note and she remembered the nurse saying R1 was outside holding on to the fence, but the note didn't say if R1 was trying to get out. V1 stated R1 was assessed as being a high risk for elopement at that point due to safety until he could be assessed. V1 stated V4 always wants to come in and look at the residents and talk to them. When asked if V4 came to the facility and assessed R1 after the 3/22/24 incident, V1 stated she wasn't sure. On 4/19/24 at 9:40 AM, V24 (Dietary Aid/Cook) stated she was driving to work the morning R1 eloped and thought maybe she saw a resident walking by a restaurant in the next town over from the facility. V24 stated she called the kitchen around 6:00 AM and talked to V8 (Cook) and asked her to check on R1. V24 stated they checked to see if R1 was at the facility. When asked if anyone from administration had spoken with her after the incident, V24 stated, No. On 4/18/24 at 10:55 AM, V8 (Cook) stated she was working on the morning of 4/13/24 and she came to work around 5:00 AM. V8 stated she got a call from V24 (Dietary Aid/Cook) around 5:30 AM, who said they may have seen R1 walking in the next town near a restaurant. V8 stated they searched the facility and couldn't find R1. V8 stated she believed someone drove to the next town and found R1 after that. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/16/24 at 3:39 PM, V9 (Certified Nursing Assistant/CNA) stated she came to work on 4/13/24 at approximately 5:45 AM and started working at 6:00 AM. V9 stated everyone was doing their normal routines and there was no indication a resident had eloped. V9 stated she was checking resident's vital signs and V26 (LPN/Licensed Practical Nurse) was passing medications like nothing was wrong. V9 stated a kitchen staff member (maybe V8/Cook) walked down the hall and after that V26 stated they needed to start looking for R1. V9 stated V26 looked a little frantic at that point. V9 stated she was told V24 (Dietary Aid/Cook) thought she saw R1 walking on the road toward the next town over. V9 stated after hearing that she realized she may have also seen R1 on her way to work but didn't see the person close enough to know if it was R1. V9 stated she told V26 she may have also seen him on her drive to work and V26 told her to go get R1. V9 stated she left the facility and drove to the next town. V9 stated she stopped at a gas station/store to see if they had seen R1. V9 stated they had seen a man walking but he had continued to walk. V9 stated she left that area and continued to drive and when she got to the interstate, she saw R1 walking under the overpass. V9 stated she parked her car and asked R1 what he was doing. V9 stated R1 said he had some in laws that lived by one of the local restaurants and he was going to see them. V9 stated she told R1 he scared them, and he got in her car, put the seat belt on, and she started to drive back to the facility. V9 stated she asked R1 what time he left the facility, and he told her about 10:00 PM the night before. V9 stated R1 said he had gone to the woods looking for a walking stick then to the railroad tracks where he found a piece of board and used that for his walking stick. V9 stated R1 told her a factory worker gave him a bag of chips and he sat and ate them. V9 stated R1's wander guard wasn't on him anymore, but she didn't know what happened to it. V9 stated R1 was in good spirits when she found him, but he said his feet and legs were very sore. V9 stated she picked R1 up at 7:00 AM and got him back to the facility at 7:08 AM. V9 stated they looked for his wander guard and couldn't find it and while she was giving her statement to administration, they put another one on him. V9 stated V26 (LPN) gave her statement to administration first and V26 told them she noticed R1 was missing between 4:30 and 5:00 AM, but she (V26) had no reason to think R1 had left the building. V9 stated V26 didn't tell anyone she couldn't find him. V9 stated the first person to realize R1 was gone was V24 (Dietary Aid/Cook) who saw him walking on the highway. V9 stated V7 (LPN/Licensed Practical Nurse) who was also working said she saw R1 around 4:00 AM coloring. V9 stated there is no way he walked that far in 30 minutes. V9 stated V7 (LPN) didn't know R1 was missing until she got the phone call from V24 around 6:44 AM. V9 stated V7 then started notifying administration. When asked if she had any concerns with how the incident was handled. V9 stated, Yes, it seems strange to me we had a resident missing and no one knew he was gone. V9 stated if they were doing bed checks every two hours, they should have known R1 was gone. V9 stated when V26 realized R1 was missing at 4:30 or 5:00 AM and didn't do anything about it, to me that is neglect. According to Google maps https://www.google.com/search?q=google+maps&rlz=1C1GCEB_enUS1019US1019&oq=google+maps&gs_lcrp=EgZjaHJvbWUqEggAEEUYOxiDARixAxjJAxiABDISCAAQRRg7GIMBGLEDGMkDGIAEMg0IARAAGIMBGLEDGIAEMhAIAhAAGIMBGJIDGLEDGIAEMhAIAxAAGIMBGJIDGLEDGIAEMgYIBBBFGDwyBggFEEUYPDIGCAYQRRg8MgYIBxAFGEDSAQgyNzg4ajBqN6gCALACAA&sourceid=chrome&ie=UTF-8 it would take the average person one hour and thirty-three minutes to walk from the facility to the location R1 was found which was 4.4 miles away. The path R1 walked was on US highway 50 which is a busy two-lane highway that is not well lit and merges into a four-lane highway once it nears the next town. This surveyor attempted to contact V26 via telephone on at least three occasions with no answer and no return phone call. V26 is an agency nurse so is unable to be contacted at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/18/24 at 10:26 PM, V7 (LPN/Licensed Practical Nurse) stated she worked from 7 PM to 7 AM on 4/12/24 and 4/13/24. V7 stated on the morning of 4/13/24, before 6:40 AM, she answered the facility phone and someone who she believed was V24 (Dietary Aid) told her they thought they saw R1 walking. V7 stated she checked with R1's nurse, started doing a head count, and had the CNA's looking for R1. V7 stated she called V49 (Wound Nurse), who didn't answer so she called V48 (MDS/Care Plan Coordinator), who answered, and then she called V1 (Administrator). V7 stated she started walking around outside the facility and when she came back in R1 was there. V7 stated she couldn't recall if she had seen R1 throughout her shift. V7 stated she does not work on R1's hall she always tries to stay on her hall close to the residents she is assigned to. On 4/18/24 at 11:11 PM, V17 (CNA) stated she was working night shift on 4/12/24 when R1 left the facility. V17 stated she really didn't know what happened. V17 stated R1 was coloring around 12:30 or 1:00 AM but she couldn't recall if she saw R1 after that. V17 stated R1 is very independent and does everything himself. V17 stated the nurse working on R1's hall was an agency nurse and she asked about R1 before 6:00 AM. V17 stated they went outside and R1's nurse went back in before she did. V17 stated then day shift arrived, and she left at 6:00 AM. V17 stated no management staff had talked to her about what occurred. On 4/19/24 at 10:10 PM, V18 (Anonymous) stated she was working night shift on 4/12/24. V18 stated she didn't think R1 had a wanderguard on. V18 stated R1 likes to roam around, and she thought he was aware of the door codes. V18 stated she did have eyes on R1, and she thought R1 could have left when they started getting residents up on the morning of 4/13/24. V18 stated she didn't hear any alarms sound which is why she said she didn't think R1 was wearing a wanderguard. V18 stated she was in R1's room tending to his roommate quite a few times through the night. V18 stated on the morning of 4/13/24 she was in R1's room around 1:00 AM and then around 3:30 AM. V18 stated R1 was in his bed at those times. V18 stated she saw R1 go to the couch around 4:45 or 5:00 AM. When asked how she became aware R1 was gone from the facility, V18 stated she got a call from management and when they asked if she was working, she told them no thinking they were talking about when R1 attempted to leave a few weeks prior. When asked if anyone from management followed back up with her, V18 stated they had not. V18 stated when she came back to work on 4/13/24 there was a manager there due to a call in and they told her to do 15-minute checks on R1 and to check the door alarms. On 4/19/24 at 10:31 PM, V20 (CNA) stated she was working on 4/12/24 when R1 left the facility. V20 stated it was a normal night and she didn't realize R1 was missing until she left around 6:30 AM. V20 stated she saw what she thought was R1 walking down the main street in the next town over. V20 stated R1 was near the interstate walking with a stick. V20 stated she called the facility and spoke with an unknown nurse and asked them to see if R1 was at the facility. V20 stated the nurse said she would and never called back. V20 stated she didn't work on R1's hall that night but she did see R1 in passing around 1:00 or 2:00 AM. V20 stated V48 (MDS/Care Plan Coordinator) called her around 8:00 AM and asked if she had heard any alarms and if she had seen R1. When asked if there was any training after the incident, V20 stated she wouldn't say training. V20 stated they had them sign a paper, but administration didn't talk with night shift. V20 stated she knows staff were talking about a nurse knowing R1 was missing about an hour before she (V20) called the facility. V20 stated she thinks they aren't noticing things like they should. V20 stated she didn't really talk with R1 much, just some small talk. V20 stated they don't get information on residents' cognitive status. V20 stated they just tell them if they are alert and oriented. V20 stated R1 seemed aware of what was going on and could carry on small conversations, but she wouldn't say he would be able to take care of himself. V20 stated she could tell R1's cognitive levels weren't at full function. (continued on next page)

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	145649	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odin Health and Rehab Center	300 Green Street Odin, IL 62870

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/19/24 at 10:21 PM, V19 (CNA) stated he was working on the night of 4/12/24 and finished his bed checks around 5:30 AM. V19 stated he got mandated to stay and worked until about 8:30 AM. V19 stated he found out around 6:30 AM that R1 wasn't in the facility. V19 stated they locked the facility down and looked for R1. V19 stated he did remember seeing R1 around 2:30 or 3:00 AM in the dining room coloring and watching tv. V19 stated administration had asked him to give a statement. V19 stated a few months back R1 said he was going to leave so they placed a wanderguard at that time and R1 was on 15 minutes checks. On 4/23/24 at 10:01 AM, V33 (Agency LPN) stated she was working on the night of 4/12/24 when R1 eloped. V33 stated R1 wasn't her resident, and she wasn't aware R1 was gone until she had left the facility. V33 stated an unknown nurse came to her around 5:45 or 5:50 AM and asked if she had seen R1. V33 stated she wasn't sure who the nurse was talking about. V33 stated the nurse described him to her and she realized she knew who R1 was. V33 stated she had seen him around 10:00 PM in the dining room coloring pages. V33 stated he was at the table closest to the doors on the right. V33 stated she saw him again in the dining room when she went to the snack machine around 12:00 or 12:30 AM. V33 stated after that she was at the nurse's station. V33 stated she shared this with the nurse and the nurse didn't look worried, so she thought she was just looking for him for morning medications. V33 stated she didn't know the nurse, but she didn't look concerned and didn't come back to say R1 was missing. V33 stated she left the facility and was getting ready to pull her car out when an unknown lady pulled in and said through her car window that she (V33) needed to write a statement. V33 stated she asked her what she needed a statement for, and the lady responded for the elopement. V33 stated she asked her what elopement and the lady responded that R1 was found by the overpass. V33 stated she thought they were talking about the one right outside the building and told the lady she would give the statement that night when she returned to the facility. V33 stated no one left a note for her or said anymore about a statement. V33 stated she was ear hustling when she returned to work, and they were saying R1 got out and was all the way in the next town. V33 stated the aids were saying they didn't even know R1 was missing. V33 stated she told the CNA's that was why it was so important for them to count the residents and even if they didn't need bed checks to make sure they were laying eyes on their residents. When asked if she was aware of any policy related to checking residents, V33 stated she thought it was a state regulation that they should be doing that. V33 stated she figured they would all know that it doesn't matter if they are independent, they still need help. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/16/24 at 2:34 PM, R1 was in the dining room participating in activities. After he was finished with the activity this surveyor asked if I could speak with him. R1 stated we could talk in the common area. R1 appeared clean and well-groomed with no obvious signs of distress. When asked if he had left the facility, R1 stated he did yesterday around 8 or 9 pm. R1 stated he didn't tell anyone he just started walking to (name of next town). R1 stated it took him all night. R1 stated he was trying to figure out where to go when a lady from the facility found him. R1 stated he had a bracelet (Wanderguard) on his ankle, but it got cut off. R1 stated he was almost to (name of next town) when he ran into a fell a and this fell a asked if he wanted him to cut it off. R1 stated the guy cut it off with his (the guys) knife. R1 stated he didn't remember if the door alarm sounded when he left the facility. R1 stated it worked today when they had me test it out. R1 stated the facility staff had him walk in front of the door to see if it worked. When asked if he had a wanderguard on at that time, R1 stated yeah and pulled his pant legs up. There was no electronic monitoring bracelet on either leg. R1 stated, Oh no, they didn't put it back on. R1 stated when he left the facility, he went out the dining room door and left when a bunch of people went out. R1 stated he figured that was the best time to leave. R1 was asked the following questions and gave the following responses. What day is it? I don't know. Season? It is supposed to be winter, but we didn't have much of a winter. Who is the president of the United States? Trump. I know it is the middle of an election year. What year is it? I don't know. What meals have you had today? I know I had breakfast. The kitchen treats me good, and they come check on me. R1 stated he didn't know why he left the facility, and he didn't really have a plan when he left. R1 stated he knew he was in the next town over and he knows people who live there but he couldn't remember where they lived. R1 stated, Memory loss is what I have problems with lately. R1 stated when he left the facility it was warm and not raining. R1 stated he wasn't injured while he was gone. R1 stated he met some guy who was going to work while he was out, and they sat down and shared a cigarette. R1 stated he (the unknown guy) was the one who cut his bracelet (electronic monitoring device) off. R1 stated when he got back to the facility the staff talked to him about how he was doing. When asked if the facility staff talked to him about what to do if he wanted to leave again, R1 stated, They didn't go into detail. R1 stated if he wants to go for a walk he just goes into the courtyard. When asked if the facility staff talked to him about signing out if he leaves again, R1 stated, No, they didn't they just mentioned to talk to someone if I wanted to leave. On 4/18/24 at 9:52 AM, R1 was sitting in the dining room/common area at the facility. R1 appeared clean and well-groomed with no signs of obvious distress. R1 was not able to tell this surveyor what the date, month, or year it was. R1 stated he was [AGE] years old. R1 is [AGE] years old. When asked what season it was, R1 stated he would need to know what month it was, and he usually just looks outside. When asked if he had breakfast R1 stated he had. When asked what he had for breakfast, R1 stated, just breakfast is all I can say. Then R1 stated he had hash browns, eggs, toast, coffee, and a donut or cookie. When asked if the facility spoke with him after he left the facility, R1 stated he couldn't remember if they did or not. R1 stated, My memory isn't that good. I am struggling with memory. When asked how long he was gone from the facility R1 stated, Most of the night. R1 stated he left around 7 or 8 PM but did stop and talk to a couple of people on the way. On 4/18/24 at 10:55 AM, V8 (Cook) stated she worked on 4/18/24 and served breakfast. V8 stated she remembered what she served to R1, and it was two biscuits, two sausages, double scrambled eggs, two bowls of cereal, milk, and juice. V8 stated there were no cookies or donuts served to R1 that she was aware of. R1's progress notes do not document any note dated 4/13/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Progress Note dated 4/14/24 documents, Continues on 15-minute visuals r/t (related to) elopement attempt. Wander guard in place and functioning. No attempts made during this shift. ROM (range of motion) WNL (within normal limits) per residents' normal functions. Denies any c/o (complaints of) pain or discomfort. No injuries noted. Respirations even and non-labored on room air. No s/s (signs or symptoms) of acute distress noted at this time. Currently resting quietly in bed with call light and frequently used items within easy reach. This note is struck out and documents, Strike Out Reason: Incorrect Documentation. Strike Out Date: 4/16/2024. R1's Elopement Risk Assessments dated 4/13/24 document a score of 18 which indicates R1 is at high risk of elopement. R1's QAPI (Quality Assurance Performance Improvement) Ad Hoc (As needed) Form dated 4/13/24 documents, Meeting Attendees: V2 (DON/Director of Nursing), V48 (MDS/Care Plan Coordinator), V47 (ADON/Assistant Director of Nurses), and V51 (Physical Therapy Assistant). Identified Opportunity for Improvement/Deficient Practice: Elopement 1. Immediate Corrective Action for those affected by the deficient practice: 4/13/24 Resident located and returned to facility. Head to toe assessment, no injuries noted, nursing assessment complete. 4/13/24 MD (physician) notification- Completed. 4/13/24 Wanderguard on and functioning- Completed. 4/13/24 Investigation initiated. - Completed. 4/13/24 Staff educated on wandering/elopement policy and responding to door alarm immediately-door alarms, supervision, wanderguard verifications- ongoing. 4/13/24 Trauma, pain, skin, elopement risk, abuse risk assessments completed, resident put on 15 min visuals for 72 hours. 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents Elopement assessment- Residents at risk- care plan reviewed with appropriate interventions in place or initiated. Elopement books updated with current assessments. Elopement assessments will be completed upon admission with additions to care plan and elopement books as indicated, i.e., high/moderate risk. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur. 100% Staff in-servicing on Elopement Policy, door alarms, supervision of residents, wanderguard verifications. 100 % Residents completed Elopement Assessment with Care Plan Reviews and Interventions Implemented as indicated. Nursing staff will visualize resident q (every) 2 hours. 4. Plan to monitor performance to ensure solutions are sustained. Nursing staff or designees will audit door alarms for functionality and sound every shift until reviewed by QA Committee. Administrator or DON will audit 2 hour rounding daily for compliance until review by QA Committee. R1's Order Recap Report dated 3/24/24 to 5/31/24 includes the following orders: Wanderguard check function Q (every) week every day shift every Fri (Friday) for Wandering . with a start date of 3/22/24 Wanderguard-Check placement every shift for Monitoring . with a start date of 3/22/24, 15-minute visual checks r/t (related to) exit seeking behaviors every shift . With an order date of 4/15/24. Accu checks and contact MD (physician) orders Notify MD if BS (blood sugar) less than 60 or greater than 400 before meals and at bedtime. R1's MAR (Medication Administration Record) dated 4/1/24 to 4/30/24 documents the wanderguard and 15-minute check, physician orders are signed as administered as ordered by the physician. R1's physician order to check R1's accu check before meals and at bedtime is signed administered as ordered each day and shift except 4/13/24 at 6:00 AM, indicating all accu checks were done as ordered except the one ordered for 6:00 AM on 4/13/24. On 4/24/24 at 1:49 PM, V2 (DON) stated she was out of town on 4/13/24 and wasn't involved in the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/24/24 at 4:11 PM, V1 (Administrator) stated on 4/13/24 at 6:35 AM, V9 (CNA) stated she was notified R1 was missing by staff member (gave initials of staff member). When asked who that staff member was, V1 stated she would have to look. (Initials were never verified and didn't match staff currently working in the facility). V1 stated at 6:44 am, V7 (LPN) was notified R1 was possibly seen near a restaurant by V24 (Diet[TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714 Based on interview, observation, and record review the facility failed to ensure medications were available and administered as ordered for 3 (R23, R24, and R28) of 13 residents reviewed for medication administration in the sample of 34. Findings Include: 1. R28's Admission Record documented R28 was [AGE] years old with an admitted to the facility of 05/05/2023. Diagnoses listed in their entirety on this document are: Hemiplegia, Unspecified Dementia, essential hypertension, Paroxysmal atrial fibrillation, peripheral vascular disease, atherosclerotic heart disease, hyperlipidemia, low back pain, gastro-esophageal reflux disease, neuromuscular dysfunction of bladder, fatty liver, unspecified psychosis, depression, bipolar disorder, and personal history of transient ischemic attack. Review of R28's Order Review Report documented the following active orders: Baclofen Oral Tablet 10 MG (milligrams). Give 10mg by mouth three times a day related to Hemiplegia, unspecified affecting left nondominant side. This orders start date is listed as 9/8/23. Mirtazapine Tablet 15 MG. Give 0.5 tablet by mouth at bedtime related to Depression, unspecified. This order start date is listed as 5/9/23. Omeprazole Oral Tablet Delayed Release 20 MG. Give 1 tablet by mouth one time a day for indigestion related to Gastro-Esophageal Reflux Disease without esophagitis. This orders start date is listed as 5/5/23. Venlafaxine HCl (Hydrochloride) Oral Tablet 75 MG. Give 1 tablet by mouth one time a day for depression/anxiety. This orders start date is listed as 8/18/23. Tramadol HCl Oral Tablet 50 MG. Give 1 tablet by mouth every 6 hours for pain. This order is documented as having a start date of 5/16/23 and end date of 5/10/24. R28's MAR (Medication Administration Record) dated March 2024, on 03/16/2024 under Mirtazapine 15 mg (milligram) tablet, 04/16/2024 at 8:00 P.M., MN (Medication not available) is documented. On the last page of the medication administration record under chart codes, MN is documented as indicating medication not available. On same document under Omeprazole 20 mg, on 03/02/2024 and 03/24/2024 6:00 A.M., there are blank squares indicating medication not given. Under Baclofen 10 mg three times a day, the following entries were documented as MN medication is not available: 03/15/2024 8:00 P.M., 03/16/2024 8:00 A.M., 03/16/2024 12:00 P.M., and 03/16/2024 8:00 P.M. Under Tramadol 50 mg every 6 hours, on 03/02/2024 06:00 A.M., 03/07/2024 6:00 P.M. and 03/24/2024 06:00 A.M. there are blank squares indicating medication not given. R28's MAR dated April 2024, under Omeprazole 20 mg (milligram), on 04/21/2024 at 6:00 A.M., there is a blank square indicating medication not given. Under Venlafaxine 75 mg on 04/13/2024 at 8:00 A.M., MN is documented indicating medication not available. On same document under Tramadol 50 mg every 6 hours, the following entries were documented as MN medication is not available: 04/06/2024, 12:00 A.M., 04/06/2024 06:00 A.M., 04/07/2024 12:00 A.M., 04/07/2024 6:00 A.M., 04/08/2024 12:00 P.M., 04/09/20024 12:00 P.M., 04/09/2024 6:00 P.M., and 04/10/2024 12:00 P.M., and 04/10/2024 6:00 P.M. Under Tramadol 50 mg every 6 hours, 04/21/2024 6:00 A.M. and 04/28/2024 6:00 P.M., are blank squares indicating medications not given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/10/2024 at 10:40 A.M. V2 (Director of Nursing/DON) stated it is her expectation that nurses should document all medications given during their shift on the resident's medication administration record. V2 also stated if there was a blank square on a medication administration record, the medication can not be confirmed as administered. The policy titled Medication Administration Policy / Procedure with a revision date of 09/27/2022 documented, 12. Chart the medication administered on the electronic medication administration record. 32619 2. R24's Face Sheet documented an admitted [DATE] and documented diagnoses including Diabetes Type 2 and Unspecified Heart Failure. R24's May 2024 Physicians Order Sheet documented an order for Potassium Chloride extended release 10 meq (milli equivalent) take one tablet every morning. On 5/7/24 at 7:50am, V10 (Licensed Practical Nurse/LPN) was observed passing medications to R24. As V10 prepared the medications for administration, she stated R24 did not have Potassium Chloride tablets in the medication cart. V10 was then observed ordering the medication online from the facility's pharmacy. V10 was then observed going to the facility's medication room and looking for a stock supply bottle, of which there were none. V10 stated she was not sure when R24's Potassium would be delivered. V10 stated she works for the corporate float pool and has not been in the facility for about a month until today, so she was unsure if not getting resident medications timely was a problem for the facility. On 5/7/24 at 11:50am, V10 stated the Potassium had not yet been delivered. R24's May 2024 Medication Administration Record documented that R24 did not receive the Potassium on 5/7/24 as the medication was not available. 36969 3. Review of R23's Admission Record documented an initial admitted to the facility as 12/19/21. R23 is documented as being [AGE] years old, with diagnoses including, but not limited to: Type 2 Diabetes Mellitus with Diabetic Polyneuropathy; Unspecified Asthma; Morbid (severe) Obesity due to excess calories; and Occlusion and Stenosis of Bilateral Carotid Arteries. On 5/7/24 at 12:25 PM, V56 (Certified Nurse Assistant, CNA) stated she was working the day that R23 was sent to the hospital after having a low blood sugar. V56 stated she believes she was entering R23's room to take her to breakfast and observed her with bubbles coming out of the side of her mouth, eyes closed, and not responding to physical or verbal stimuli. V56 stated she knows R23 is diabetic, so she called for the nurse, V36 (Licensed Practical Nurse, LPN), who immediately responded. V56 stated she has no further knowledge of anything that occurred during R23's care at that time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 10:00 AM, V36 (LPN) stated that it was before lunch time on the day the CNA (V56) came and got her and said that R23 wasn't responding. V36 stated she immediately went to check on R23 and found that she was very lethargic with her eyes open, but not talking. V36 stated that she took R23's blood sugar, receiving a result of 37. V36 said V2 then came to assist. V36 stated R23 was attempted to be given oral glucose gel as ordered but couldn't swallow and the gel was running back out of her mouth. V36 stated she went to call the ambulance and V2 went to get IV (intravenous) supplies and start the IV. On 5/7/24 at 12:48 PM, V36 stated that V2 (DON) was coming out of the morning meeting when she alerted V2 that she needed help with R23. V36 stated that she called the local ambulance company for transport to the hospital, while V2 started the IV (Intravenous Therapy). V36 stated she wasn't sure where the IV order came from, because she isn't a Registered Nurse, so would have to check with V2. On 5/7/24 at 12:58 PM, V2 stated that she was notified by V36 one morning after coming out of morning meeting that she needed help with R23. V2 stated that R23 was lethargic, and her blood sugar was checked, with a reading of 37. V2 stated R23 was not responsive enough to take the oral glucose gel, as they tried but it was just running out of her mouth. V2 stated V36 went to call the ambulance and she went to get IV supplies and start a Dextrose infusion. V2 stated by the time the ambulance arrived R23 was improving and more alert. On 5/8/24 at 1:05 PM, V2 stated that the infusion that was given to R23 on 4/9/23 when her blood sugar was 37, she believes was a dextrose 5% bag of solution. R23 stated that herself, V1 (Administrator), and V48 (MDS/Care Plan Coordinator) all were discussing ways to quickly get R23's blood sugar up as they were all present when V36 came to get V2 regarding R23's emergent hypoglycemic status. V2 stated that an IV with dextrose infusion was mentioned, so V36 spoke with the doctor and obtained the order. V2 confirmed that an IV infusion of dextrose is not an intervention that can be implemented without a physician's order. V2 stated that she started the IV line to R23 and ran the dextrose fluid wide open. V2 stated that shortly after she began the dextrose fluid administration ambulance personnel arrived and took over. V2 confirms that it was an error that the physician's order for the dextrose was not documented or documented on the Medication Administration Record as being given. V2 acknowledges that any medication given should be documented in the resident's record. On 5/7/24 at 1:39 PM, V2 again confirmed the Dextrose IV is not a standing order. V2 stated that V36 was the nurse who said the doctor was on the phone and gave the order to administer dextrose. On 5/8/24 at 12:50 PM V36 (LPN) stated that on 4/9/24 regarding R23's blood sugar event when her level was 37, she did not contact the physician at the time of the event, but rather after R23 had already left the facility via ambulance, due to tending to the emergent medical needs of R23. V36 stated that she did not receive an order for R23 to have Dextrose IV administered, and thinks that was just quick thinking on V2's part. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's local ambulance report dated 4/9/24 documented the ambulance company received the call for assistance needed at 10:32:01 AM. The call is documented as the facility reporting a female with low blood glucose. An ambulance is documented as being dispatched at 10:32:54 AM with lights and sirens. Upon their arrival to the facility at 10:40:56 AM, R23 is documented as being pale, warm, dry, PERRL (pupils equal reactive and responsive to light), airway patent, breathing adequate, but not responding to verbal stimuli. Upon EMS (Emergency Medical Service) arrival, the facility staff were observed administering D5 (5% dextrose) intravenously. Facility staff are documented as reporting R23 had been found cool and clammy, lethargic, with a blood sugar of 37 for an unknown amount of time that she had been that status. The facility is documented as reporting they initially tried to administer R23 oral glucose, but she wasn't able to swallow the solution. The facility reported starting a 22 gauge IV (intravenous) line to R23's right hand, administering approximately 50 mL (milliliters) of D5. The ambulance company is documented as taking R23's blood glucose level upon their arrival with her level now being 83. R23 departed the facility via EMS at 10:55:07 AM, arriving at the local hospital Emergency Department for evaluation and treatment at 11:09:26 AM. R23's Progress Notes dated 4/9/24 at 10:52 AM documented a Nursing Note that stated, Resident is in a very deep sleep, not responding when talking (sic) to her Accu check is 37. Attempted to give glucose gel by mouth resident is spitting it out and won't swallow, attempted to give it with a syringe and she took in approximately half a tube. This nurse started getting her paperwork ready and called (name of local ambulance company) while V2 started an IV and dextrose. EMT (Emergency Medical Technician) arrived resident did open her eyes and spoke a few words BS (blood sugar) up to 83 at this time. Resident oof (out of facility) to ER (emergency room). No documentation of physician notification or any orders received were noted to be documented on 4/9/24. Review of R23's Order Summary Report for April until May 7, 2024 documented an active as needed order with a start date of 11/16/22 for Glucose 5 Gel 40% (Glucose) Give 1 unit by mouth as needed for dm (diabetes mellitus) give 1 unit for hypoglycemia recheck BS and repeat as needed call MD (doctor of medicine) after use. Review of this order summary documents no order for a dextrose IV infusion. Review of R23's Medication Administration Record for 4/1/2024 - 4/30/2024 documented no entries for Glucose Gel or Dextrose IV being administered during this time period. The Change of Condition Protocol with a date revised of 1/23/23 documented, .7. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response. 8. The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. a. the nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. The note dated Medication Orders Procedure documented, The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders . 2. A current list of orders must be maintained in the clinical record of each resident.

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Odin Health and Rehab Center	300 Green Street Odin, IL 62870

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36969 Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 3 (R23, R10, R27) of 13 residents reviewed for medication errors in the sample of 34. This resulted in R23 experiencing a blood glucose level of 37, altered mental status and being transported by EMS (Emergency Medical Services) to the Emergency Department for evaluation and treatment. Additionally, this failure resulted in R27 experiencing anxiety and an increase in behavioral symptoms, requiring an inpatient psychiatric hospitalization . The immediate Jeopardy began on 4/9/24 when insulin was administered to R23 without first performing a blood glucose check as ordered. V53 (Chief Clinical Officer) and V66 (Regional Operations Clinical Consultant) were notified of the Immediate Jeopardy on 5/8/24 at 2:40 PM. The surveyors confirmed by observations, interview, and record review that the Immediate Jeopardy was removed on 5/8/24 but noncompliance remains at Level Two due to additional time needed to evaluate the implementation and effectiveness of in-service training. Findings Include: 1. Review of R23's Admission Record documented an initial admitted to the facility as 12/19/21. R23 is documented as being [AGE] years old, with diagnoses including, but not limited to: Type 2 Diabetes Mellitus with Diabetic Polyneuropathy; Unspecified Asthma; Morbid (severe) Obesity due to excess calories; and Occlusion and Stenosis of Bilateral Carotid Arteries . R23's Order Summary Report documented an active physician order, with a start date of 11/4/23 for Accu Checks BID (twice a day). Before breakfast and before bedtime. Notify MD (Doctor of Medicine) if BS (blood sugar) <(less than) 60 or > (greater than) 400 two times a day. R23's active orders on 4/9/24 include the administration orders of, Humulin 70/30 Kwikpen (70-30) 100 UNIT/ML (milliliter) Suspension pen-injector. Inject 40 units subcutaneously in the morning for DM (diabetes mellitus) type 2 Victoza Solution Pen-Injector 18 MG (milligrams)/3 ML (Liraglutide). Inject 1.8 mg subcutaneously in the morning for DM. R23's Medication Administration Record for 4/1/24 - 4/30/24 documented no Accu Check results on 4/9/24 at 0600, with the entry of 9. 9 is documented as representing, Other / See Progress Notes. Progress Notes dated 4/9/24 at 5:25 AM document the notation regarding Accu Checks as Not administered. Additional review of the Medication Administration Record for 4/1/24 - 4/30/24 documented despite R23 not having a blood glucose level completed on the AM of 4/9/24, R23 was administered subcutaneously 40 units of Humulin 70/30 Insulin at 5:21 AM and 1.8 mg of Victoza at 5:17 AM. (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/7/24 at 2:52 PM, V43 (Agency Licensed Practical Nurse, LPN) stated that she was the nurse that was working at the facility on 4/9/24. V43 stated that she was unable to check R23's blood sugar on the morning of 4/9/24, as she couldn't find any glucose monitoring strips to check it with. V43 stated she isn't sure the oncoming nurses name, since she only works at the facility as agency staff but reported to her that morning that R23's blood sugar hadn't been checked yet due to having no strips. V43 stated the nurse told her they would find some or go buy some. V43 stated she documented the blood sugar in the Medication Administration Record (MAR) as not taken. V43 stated she left for the shift and never heard anything further regarding any concerns presenting after the insulin administration. In an additional interview with V43 on 5/7/24 at 3:36 PM, V43 confirmed that the shift she worked was 6PM-6AM beginning on 4/8/24, with the shift ending at 6AM on 4/9/24. V43 stated along with herself, two other nurses were also working at the facility that night. V43 confirmed she did not contact the physician to provide notification of being unable to check blood sugar levels due to a lack of strips or receive further orders. V43 confirms she administered insulin without knowing residents current blood sugar levels. V43 stated she did this as one of the other nurses working that night, who she didn't know their name, stated they had contacted V1 (Administrator) regarding not having blood sugar testing strips available. V43 stated V1 reportedly said they would get some strips and have them checked that morning. On 5/8/24 at 10:13 AM V7 (LPN), stated that she recalled working the night of 4/8/24, into the morning of 4/9/24. V7 stated that she recalled there being a shortage of glucose testing strips that night. V7 stated that she was working C Hall and had just enough strips to check her resident's glucose levels on that hall. V7 stated that she did not know of any other strips available in the facility to share with other halls in the facility that were short of strips. V7 stated if she recalls correctly, V6 (Registered Nurse/RN) was working that night and had contacted V1 regarding the glucose testing supply shortage by phone. V7 stated to her knowledge, the facility was going to send someone to get more strips from the store and said they would just check the glucose levels of those still needing their levels checked later that morning after they obtained more strips. On 5/8/24 at 2:00 PM, V6 (RN) stated that she recalled working on 4/8/24 into the morning of 4/9/24. V6 stated she had searched the entire facility looking for glucose strips as nursing staff had identified there would be enough strips for C hall to complete their AM blood glucose checks, but none for A or B halls. V6 stated V2 (Director of Nursing) was notified and instructed V6 to just document the blood glucose checks as not being done, and she would send someone from day shift first thing in the morning to get more strips. V2 communicated that day shift would take care of performing the accu checks and insulin administration. V6 stated nursing staff were never instructed to administer insulin without completing a blood glucose check. On 5/7/24 at 12:25 PM, V56 (Certified Nurse Assistant/CNA) stated she was working the day that R23 was sent to the hospital after having a low blood sugar. V56 stated she believes she was entering R23's room to take her to breakfast and observed her with bubbles coming out of the side of her mouth, eyes closed, and not responding to physical or verbal stimuli. V56 stated she knows R23 is diabetic, so called for the nurse, V36 (LPN), who immediately responded. V56 stated she has no further knowledge of anything that occurred during R23's care at that time. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/7/24 at 10:00 AM, V36 (LPN) stated that it was before lunch time on the day the CNA came and got her and said that R23 wasn't responding. V36 stated she immediately went to check on R23 and found that she was very lethargic with her eyes open, but not talking. V36 stated that she took R23's blood sugar, receiving a result of 37. V36 said V2 then came to assist. V36 stated R23 was attempted to be given oral glucose gel as ordered but couldn't swallow and the gel was running back out of her mouth. V36 stated she went to call the ambulance and V2 went to get IV (intravenous) supplies and start the IV. V36 stated at the time the 37 blood sugar was taken, the facility only had two blood glucose strips in the entire facility available for use. One of the strips was used to obtain the 37 reading. V36 stated R23's blood sugar was not taken again until the ambulance arrived, and she isn't sure if the ambulance took the blood sugar reading when they arrived, or the facility used their last strip. V36 stated that V2 had got the IV started and was able to infuse dextrose. V36 stated that V58 (CNA Supervisor) left the facility with the bottle of the blood glucose strips came in to go to (local store) and try and buy more strips. V36 stated that (local store) did not sell the strips that could be used with the facility's machines so he purchased a glucose monitor and the strips that could be used until their new strips came in. V36 stated V58 is responsible for ordering the strips and does not know why there was a shortage at that time. V36 stated there are other diabetic residents in the facility besides R23 who require glucose monitoring. V36 stated she isn't sure what she would have done if someone else needed blood glucose monitoring when strips weren't available. V36 stated luckily nobody needed their glucose checked during the time there was a shortage of strips and V58 was hurrying as fast as he could. R23's Progress Notes dated 4/9/24 at 10:52 AM documented a Nursing Note that stated, Resident is in a very deep sleep, not responding when talking (sic) to her accu check is 37. Attempted to give glucose gel by mouth resident is spitting it out and won't swallow, attempted to give it with a syringe and she took in approximately half a tube. This nurse started getting her paperwork ready and called (name of local ambulance company) while V2 started an IV and dextrose. EMT (Emergency Medical Technician) arrived resident did open her eyes and spoke a few words BS (blood sugar) up to 83 at this time. Resident oof (out of facility) to ER (emergency room). R23's local ambulance report dated 4/9/24 documented the ambulance company received the call for assistance needed at 10:32:01 AM. The call is documented as the facility reporting a female with low blood glucose. An ambulance is documented as being dispatched at 10:32:54 AM with lights and sirens. Upon their arrival to the facility at 10:40:56 AM, R23 is documented as being pale, warm, dry, PERRL (pupils equal reactive and responsive to light), airway patent, breathing adequate, but not responding to verbal stimuli. Upon EMS (Emergency Medical Service) arrival, the facility staff were observed administering D5 (5% dextrose) intravenously. Facility staff are documented as reporting R23 had been found cool and clammy, lethargic, with a blood sugar of 37 for an unknown amount of time that she had been that status. The facility is documented as reporting they initially tried to administer R23 oral glucose, but she wasn't able to swallow the solution. The facility reported starting a 22-gauge IV (intravenous) line to R23's right hand, administering approximately 50 mL (milliliters) of D5. The ambulance company is documented as taking R23's blood glucose level upon their arrival with her level now being 83. R23 departed the facility via EMS at 10:55:07 AM, arriving at the local hospital Emergency Department for evaluation and treatment at 11:09:26 AM. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R23's local hospital report dated 4/9/24 documented R23 presented with a chief complaint of low blood sugar. Per the ambulance company, R23 was unresponsive, cold and clammy with staff blood sugar noted to be 37. Once EMS were on the scene, R23's glucose level was checked, with a level then of 83. 10% dextrose was started and blood sugar rechecked, now at 76. R23 is documented as being confused, as her normal status, but reports she doesn't think she ate anything that morning. A fingerstick glucose level completed at the hospital prior to discharge back to the facility was 104, with a normal reference range listed as 70-108. R23 is documented as discharging back to the facility on [DATE], with the diagnoses of Hypoglycemia and History of Diabetes, with no new orders. R23's Hospital Discharge Instructions includes the notation of Please make sure patient eats before she gets her insulin to help decrease the potential for low blood sugar episodes. R23's Eating & Amount Eaten log at the facility reviewed for 4/9/24 documented no meal intake in the 6AM - 2PM entry slot. R23's Progress Notes dated 4/9/24 at 3:27 PM documented, Resident returned from (local hospital) dx (diagnosis) hypoglycemia BS is now up, received paperwork to educate resident. On 5/8/24 at 9:02 AM, V62 (emergency room Physician) confirmed he was the physician who had seen R23 in the local emergency roiagnom on [DATE]. V62 confirmed R23 was seen for hypoglycemia needs. V62 stated in reviewing his notes, upon EMS arrival to the facility, it looks like R23's glucose level was up to 83, after the administration of IV dextrose. The glucose level was initially documented as being 37. V62 confirmed that R23's hypoglycemia could have been a direct result of insulin being administered without first checking the blood glucose level. V62 acknowledged with severe cases in a resident with diabetes, if abnormal glucose levels are not monitored, medications inappropriately given, or levels left untreated, there is a potential for death. On 5/7/24 at 12:58 PM V2 (Director of Nursing/DON) stated that she was notified by V36 (LPN) one morning after coming out of morning meeting that she needed help with R23. V2 stated that R23 was lethargic, and her BS was checked with a reading of 37. V2 stated R23 was not responsive enough to take the oral glucose gel, as they tried but it was just running out of her mouth. V2 stated V36 went to call the ambulance and she went to get IV supplies and start a Dextrose infusion. V2 stated by the time the ambulance arrived R23 was improving and more alert. V2 cannot say if the blood sugar was re-checked by the facility or the ambulance company. V2 stated other than that day she is not aware of any time when there has been a blood glucose monitoring strip shortage. V2 stated V1 was the staff member who sent V58 to (local store) to buy more glucose test strips. On 5/7/24 at 4:10 PM, V1 (Administrator) stated that she doesn't recall the specific date or who she was notified by regarding the need for glucose testing strips. V1 stated it could have possibly been V2 because she was looking for the facility payment card to send for strips to be bought. V1 stated she is not aware of anytime the facility has not had test strips available for use. V1 stated she never instructed staff to administer insulin without knowing the blood sugar. V1 stated her expectation is for staff to notify the physician for abnormal blood sugar levels as outlined in that resident's plan of care and not administer insulin without knowing the resident's blood sugar level. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/7/24 at 10:17 AM V58 (CNA Supervisor) stated he was aware of the time when there was a shortage of blood glucose testing strips at the facility. V58 stated he was sent to (local store) to buy more strips, but (local store) didn't carry the kind of strips needed. V58 stated he used the facility payment card to purchase an accu check machine and testing strips for the facility use. V58 stated the truck with supplies was due at the facility the next day, so the facility just needed supplies to hold them over a day. V58 confirmed he does the ordering of glucose strips for the facility and they just went through them faster than expected. R23's Plan of Care with a created date of 12/22/21 documented a focus area for (R23) has Diabetes Mellitus. The goal of this focus area is that (R23) will have no complications related to diabetes through the review date. Interventions/Tasks listed to help fulfill this goal include, Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. 2. Review of R10's Admission Record documented an original admitted to the facility as 5/10/19. R10 is documented as being [AGE] years old, with diagnoses including, but not limited to: Type 2 Diabetes Mellitus with Hyperglycemia; Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified; Peripheral Vascular Disease, Unspecified; Chronic Obstructive Pulmonary Disease, Unspecified. R10's Order Summary Report documented an active physician order, with a start date of 1/22/24 for Accuchecks and contact MD orders if diabetic (BS <60 or >400) before meals and at bedtime. R10's active orders on 4/9/24 include, Basaglar KwikPen Subcutaneous Solution Pen-injector 100 Unit/ML. Inject 60 unit subcutaneously every 12 hours for diabetes . Admelog SoloStar Subcutaneous Solution Pen-injector 100 Unit/ML. Inject 9 unit subcutaneously one time a day for diabetes AND Inject 18 unit subcutaneously one time a day for diabetes AND Inject 9 unit subcutaneously one time a day for diabetes. R10's Medication Administration Record for 4/1/24 - 4/30/24 documented no Accu Check results on 4/9/24 at 6:30 AM, with the entry of 9. 9 is documented as representing, Other / See Progress Notes. Progress Notes dated 4/9/24 at 5:37 AM document the notation regarding Accu Checks as Not administered. Additional review of the Medication Administration Record for 4/1/24 - 4/30/24 documented despite R10 not having a blood glucose level completed on the AM of 4/9/24, R10 was administered subcutaneously 18 Units of Admelog Solostar Insulin at 5:10 AM and 60 Units of Basaglar Kwikpen at 5:10 AM. R10's Plan of Care with a date initiated as 3/13/23 documented a Focus area of, The resident has Diabetes Mellitus. The Goal of this area is listed as, The resident will have no complication related to diabetes through the review date. Interventions/Tasks documented include, Accu Checks as ordered per M.D .Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. The facility policy titled, Insulin Administration via vial procedure (undated) documented the purpose of the policy is, To provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) to include, .2. Check blood glucose per physician order or facility protocol. The policy titled Blood Glucose Monitoring with an issue date of 4/6/23 documented the purpose of the policy is, To provide staff with guidelines for the proper procedures in monitoring blood glucose, while monitoring blood glucose levels . The policy goes on to state, Blood glucose monitoring will be done on all residents with a Physician's order. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the current facility assessment dated for 2023/2024 documented Conditions Diseases the facility provides care for includes Diabetes (all types). Competencies included for this condition include but are not limited to insulin management. 32619 3. R27's Face Sheet documented an admitted [DATE] and listed diagnoses including Alzheimer's Disease, Depression, Anxiety, and Personal History of Suicidal Behavior. A Minimum Data Set, dated dated dated [DATE] documented a Brief Inventory for Mental Status Score of 2, indicating R27 has severe deficits in cognitive functioning. A Telephone Order Sheet dated 1/16/24 documented an order for hydralazine 25mg (milligrams) one tablet three times daily. R27's Current Order Review Report Dated 5/10/24 documents and order for Olanzapine (Zyprexa) Oral Tablet 2.5 MG (Milligrams) give one tablet by mouth in the morning related to dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance with a start date of 11/18/23. This same order report also documents and for for Olanzapine Oral Tablet 5 MG give one tablet by mouth at bedtime related to dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance with a start date of 11/17/23. A 1/16/24 Nursing Progress Note documented, Spoke with M.D. (Medical Doctor) re (regarding) resident is very anxious and agitated. N.O. (New Order) (given for) hydralazine 25mg 3 times daily. The next Nursing Progress Note in the record, dated 1/18/24 documented, Resident's husband was here visiting and addressed wife's increased agitation, and further documented, Notified (V27, Primary Care Physician), of the above situation and received orders to send to the ER (emergency room) at (a local hospital) for a Psychiatric Evaluation. A Discharge Summary from a local hospital dated 1/26/24 stated, Date of Admission: 1/18/24. (R27) arrived (from the facility) with a complaint of altered mental status, increased anger and irritation. Husband informed ER staff that he wasn't happy that she was sent to ER because now he will have another bill to pay, (and) is upset because the nursing home doesn't have her medications that she needs. Discharge instructions: Stop taking (this) medication: hydralazine 25mg.(milligrams). (Increase) Zyprexa to 5mg one tablet twice daily. R27's January 2024 MAR (Medication Administration Record) documented that R27 received the hydralazine three times daily on both 1/17/24 and 1/18/24. This MAR also documented that R27 did not receive Zyprexa 2.5mg one tablet in the a.m. on 1/13/24 and 1/14/24. On 5/3/24 at 12:40pm, R27 was observed in the facility's dining room self-ambulating with the one-to-one supervision of V58 (Certified Nursing Assistant Supervisor). R27 was alert only to herself and was visibly upset and agitated. On 5/8/24 at 8:55am, V71, R27's Power of Attorney, stated R27 was sent to a local hospital behavioral health unit on 1/18/24 due to an increase in anger and irritability and, Not getting one of her medications, I'm not sure which one. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/8/24 at 10:20am, V36 (LPN) stated when she called V27 on 1/16/24, V27 had ordered hydroxyzine 25mg one tablet three times daily for anxiety, not hydralazine, but she must have written the order as hydralazine. V36 stated she was not aware of this error til now. V36 stated she was not aware of R27 missing any doses of Zyprexa. On 5/8/24 at 9:20am, V47 (Assistant Director of Nurses/ADON) stated she was not hired until March of 2024 and does not know anything about R27's medications. On 5/8/24 at 1:40pm, V2 (DON) stated she was hired in January 2024 after the errors occurred and she does not know anything about it. On 5/10/24 at 7:55am, V27 stated on 1/16/24 he had ordered Hydroxyzine 25mg one tablet three times daily for R27, not Hydralazine. V27 stated hydralazine is used for the treatment of hypertension, and hydroxyzine is used for the treatment of anxiety. V27 stated this was the first he was hearing about the medication error. V27 stated had he known, he would have discontinued the hydralazine and ordered R27's blood pressure to be monitored three times daily for 7 days, and if R27 had displayed any negative effects from the hydralazine he would have ordered her to be sent to the ER. V27 stated additionally, the facility had not notified him of the morning doses of Zyprexa not being available. On 5/10/24 at 10:00 am, V1 stated she was not aware of the medication error with the hydralazine, nor of R27 not getting the morning dose of Zyprexa for two days. According to information on The Physicians Desk Reference website, https://www.pdr.net/drug-summary/?drugLabelId=738, hydralazine is indicated for the treatment of hypertension. There is no documentation in this guidance to indicate hydralazine is used in the treatment of anxiety. A Medication Error Policy dated 7/16/23 documented, Medication/Treatment errors shall be documented as required. A medication error shall be defined as any variation in administration of medication from the physicians orders and/or facility policy. The Immediate Jeopardy that began on 4/9/24 was removed on 5/8/24 when the facility took the following actions to remove the immediacy. 1) Immediate actions taken for residents identified: R23 was sent to the ER and received care for hypoglycemia on 4/9/24. 2) How the facility identified other residents who could potentially be affected: All residents that are diabetic, have physician's orders for accuchecks, and receive insulin have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: Facility staff were educated by phone or in person prior to start of scheduled next shift. Facility nurse staff will not be allowed to work until the following categories have been in-serviced: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licensed nursing staff were educated on the Accucheck policy by: (V72), RN Regional Nurse Consultant on 5.8.2024. with emphasis on obtaining and documenting as ordered. Licensed nursing staff were educated on Insulin Administration by: (V72), RN Regional Nurse Consultant on 5.8.2024 with an emphasis on insulin being administered as ordered and in accordance with current standards of practice. Education was provided for licensed nursing staff of what to do when they don't have appropriate or adequate diabetic supplies on 5.8.24 by: (V72) RN, Regional Nurse Consultant. Facility did an inventory for accucheck test strips with an estimated supply of 30 days. Illinois Department of Professional Regulation was contacted by: (V75), Chief Executive Officer via email on date 5.8.24 involving incident on 4.9.24. Facility has completed a full facility review of all residents that have diabetes with orders for accuchecks and insulin on 5.8.24, with reviews and updates to their plan of care as needed. Facility company management reviewed and/or revised any policies and procedures to ensure necessary care and services are provided to residents with Diabetes Mellitus on 5.8.24. Those polices consisted of: Medication Administration. Insulin Administration. Following Physician's orders. Accucheck policy. Change of Condition Policy. Medication Error Policy. Those that reviewed those policies were: (V53) RN, Chief Nursing Officer (V72), RN Regional Clinical Consultant (V66), Regional Operations/Clinical Consultant (V75), Chief Executive Officer. 4) How the corrective actions will be monitored: The Director of Nursing or designee will complete random audits of 5 residents per week for a period of 8 weeks of the following categories: 1.) Accucheck was completed per physician's orders and documented. 2.) Insulin was administered as per physician's orders and documented. 3.) Appropriate and adequate supplies to complete per physician's orders. Any issues with accucheck completion of insulin administration will be addressed per policy and ad hoc education will be provided at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145649	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odin Health and Rehab Center	300 Green Street Odin, IL 62870

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Results of the above reviews will be discussed at a weekly quality assurance meeting for a period of 4 weeks and will provide additional education as needed and implement interventions for improvement until resolution. Date of Removal: 5/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145649	A. Building B. Wing	05/15/2024

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 36969 Based on interview and record review, the facility failed to ensure performance improvement activities were implemented to track medical errors and adverse events, analyze causes and implement preventative actions/mechanisms for Quality Assurance (QA) and resident care. This failure has the potential to affect all 89 residents residing in the facility. Findings Include: Facility Medication Error reports dated 11/3/23 through 5/3/24 documented that R29 and R25 were the only residents noted to have medication errors in the facility during this time. On 5/10/24 at 11:30 AM, V66 (Regional Operations Clinical Consultant) acknowledged that the facility should have identified medication errors that also occurred on 4/9/24 involving R23 and R10, in which insulin was administered without first completing blood glucose testing as ordered. V66 further acknowledged that the facility should have identified another medication error involving R27 from 1/16/24 - 1/18/24 in which R27 received Hydralizine 25 MG TID (three times a day) instead of Hydroxyzine 25 MG TID as ordered. The medication errors involving R23 and R27 both resulted in local hospital admissions and/or emergency room evaluation. On 5/8/24 at 12:32 PM, V53 (Chief Clinical Officer) confirmed through her review of the facility's Quality Assurance minutes and documents, there were no concerns regarding medication availability, medication errors specific to R23 and no supply concerns noted or identified in the QA minutes or documentation. A Medication Error Policy dated 7/16/23 documented, Medication/Treatment errors shall be documented as required. A medication error shall be defined as any variation in administration of medication from the physician's orders and/or facility policy. On 5/10/24 at 8:06 AM, V27 (Medical Director) stated he was not aware of anytime the facility did not have blood glucose testing strips readily available, in which insulin was administered without checking glucose levels. V27 also confirmed he was not aware of any medication errors involving R27. V27 confirmed he is the current medical director of the facility and would be the physician involved in the facility's Quality Assurance (QA) meetings. V27 stated this is the first I'm hearing of this when describing an incident in which R23 was administered insulin without having a glucose level checked, resulting in a glucose level of 37. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145649	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The undated facility policy titled, QAPI (Quality Assurance and Performance Improvement) documents, A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments .It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). This same policy further documents, It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences .The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered .Systematic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement. Review of the facility policy titled, Quality Assurance with a date revised as 7/20/22 documented, The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents. The facility's Midnight Census report dated 4/16/24, documented a facility census of 89.