Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145649	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Odin Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm 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** 48356 Based on interview and record review the facility failed to ensure residents were free from abuse from staff for 1 of 3 residents (R2) reviewed for abuse and neglect in the sample of 10. Findings include: R2's Admission record, dated 07/23/24, documents admission to the facility on [DATE] with diagnoses in part of Alzheimer's, dementia in other disease classified elsewhere with other behavioral disturbances, depression, anxiety, personal history of suicidal behavior, restlessness and agitation, and chronic pain. R2's Minimum Data Set (MDS), dated [DATE], documents in Section C a BIMS (Brief Interview for Mental Status) score of 3 which indicates R2 has severely impaired cognition. R2's current care plan documents on 01/30/24, R2 has the potential for abuse/neglect due to personal history of, is at high/medium/low risk for abuse, inappropriate behaviors affecting others such as provoking, distrustful actions or comments, attention seeking outburst, invading other's space and property, rummaging through belongings or wandering in and out of others spaces, underlying factors that increase vulnerability; include such as dementia, confusion, poor judgement, wandering and giving away personal property. Goal is that R2 will experience no present/future problems related to abuse/mistreatment/violation. R2's interventions include assess coping skills and support system, encourage support system involvement, consult psychiatry as indicated, give choices regarding personal care and choices of activities, and notify MD (Medical Doctor) of any at risk behavior. R2's progress note dated 06/18/24 at 5:58PM documents the following in part- Allegation was made regarding facility staff member apparently showing pictures of R2 to community. Investigations underway and immediately being carried out. R2 is A (Alert) and O (Oriented) x 1. POA (Power of Attorney), husband, and MD (Medical Doctor) all notified of situation. Report form IDPH (Illinois Department of Public Health) notification initial report dated 06/18/24 at 6:10PM documents: Date of Incident: 06/18/24. Time of incident: 5:00PM. Name of resident R2. Allegation of inappropriate cell phone usage. Staff member immediately suspended. Nursing staff assessed. Administrator immediately notified. Investigation initiated. Final report to follow. Alleged abuse inappropriate cell phone usage and physical. MD notified, Family notified, Police notified, and ombudsman notified. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A witness statement dated 06/18/24 completed by V2 (Director of Nursing/DON) documents Resident name R2, Name of Witness V2, title of witness DON (Director of Nurses). V2 was asked by a V6 (member of the community) if we had a resident named R2's first name because V5 (Certified Nurse Assistant/CNA) has shown her (V6) and two other people in the community a video V5 (CNA), had taken while here at work. The video was of a resident who V6 stated was walking around with staff and repeating My name is R2's first name and everybody hates me. V2 stated that she reported this incident to the administration. On 07/23/24 at 2:00pm V1 (Administrator) provided a paper with no date and no time. The document had V6's name on top of the paper along with investigator listed as V3 (Corporate Human Resource/HR) then under investigator it states: Concerns regarding V5 and HIPPA (Health Insurance Portability and Accountability Act) of a resident at the facility. Document has a documented conversation in part between V3 and V6. These questions were asked to V6 by V3. What is your relationship to V5? V6 respond she is a friend an acquaintance. Do you work for the facility? V6 respond no. Can you tell me about the concerns that you have about V5? V6 responded there was a day that V5 was at my house on the porch, we were all sitting there, just me (V6), V5, and a few friends. We were all discussing something when V5 starts laughing and says, oh I have to show you this video. V6 said that she did not see the video, but from where she was sitting, she heard the video. V6 said in the video there was someone who said My name is R2's first name and no one likes me V6 said that V5 said that R2 says this every day and V5 said she did one on ones with her. V6 said everyone started laughing and V5 put her phone away. V6 said she felt as though this is wrong because you're not suppose to take videos of people especially if you work in a nursing home (facility). V6 said that she knows this is a violation of HIPPA (Health Insurance Portability and Accountability Act). V6 said the next day she called V2 (DON) at the facility because V5 (CNA) works at the facility and asked if they had a resident named R2 and does R2 say the same exact words every day. V6 said that V2 (DON) was surprised and didn't say anything further. Did these other friends work at the facility? V6 responded no. Do you have any concerns? V6 responded yes, she thinks V5 knows that she knows about this and that V6 reported V5. V6 said that she will deal with V5 herself but I'm sure V5 knows. On 07/23/24 at 2:10PM, V1 (Administrator) stated that she was not the administration when the incident with V5 and R2 happened. V1 stated that she knows that V5 had a video of R2 on her phone. V1 said that V6 had contacted V2 and told her that V5 was showing a video of R2. V1 said that V3 (Corporate Human Resource) did an interview with V6. V1 said that she knows V5 was terminated related to the video on her phone. Verification of incident investigation/administrative summary form dated 06/18/24 documents under summary of investigative findings: through discussions with individuals with direct knowledge and review of the resident clinical record including the report of incident SBAR (Situation, Background, Assessment, Recommendation)/COC (Continuity of Care) and the post occurrence IDT (Interdisciplinary Team) walking rounds: Documents a comprehensive investigation was initiated and it was discovered that V5 discussed R2 (Resident) with friends not affiliated with the facility. V3 called and spoke to V6 friend of V5 who confirmed that V5 shared information about R2. V5 remained on suspension throughout the investigation. Upon completion of this investigation, it appears that V5 purposefully shared information about R2. V5 was terminated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Witness statement dated 06/23/24 documents date and type of event: 06/18/24 allegation of abuse. Resident name R2. Name of Witness V5. Interview of V5 over the phone asked if she had taken video or picture which V5 denied ever taking or having on her phone. V5 reported she would not have a video or picture on her phone. V5 was asked if she had ever observed any staff taking pictures or video of resident on their personal phones? V5 responded no. Corrective action/Termination Form dated 06/25/24 documents Employee name V5. Title Certified Nurse Assistant. Termination. Details of incident: Disregard of company policies. Detail of Incident per investigation on 06/18/24 the facility concluded that V5 violated cell phone policy. Reference Violation: the facility handbook cell phone/recording devices which says no employee may use a camera phone function on any phone or while performing work for the company. On 07/24/24 at 11:55AM, V3 stated that she only did the interview with V6. V3 said she wasn't involved in the rest of the investigation. V3 said that the old administrator of the facility was the one involved in the investigation. V3 said she would have been the one to know what kind of investigation this would have been. V3 said that she was just confirming what V6 had told V2. V3 said that she was only involved in the investigation, because V6 wanted to talk to someone in human resource and V3 was the only one available. V3 stated that she didn't know if it was an abuse allegation or if it should be. V3 said that all she knows about the incident was the witness statement she took from V6. V3 said that she believes the statement she took from V6 was on 06/18/24. On 07/24/24 at 12:03PM, V2 (DON) stated that she received a phone call from V6 who is one of her friends, stating that she was at a get together with V5. V2 said that V6 and V5 are not friends they just have mutual friends. V2 said that V6 told her that they were all sitting out on a porch when V5 pulled out her cell phone and started playing a video of a lady that was saying My name is (R2's first name) and everybody hates me. V2 said that V6 told her that V5 has to do one on ones with R2. V2 said that she knew who the video was of right away. V2 said there was no way that V6 would know this much information about R2 unless V5 did show them a video. V2 said that R2 makes that statement often so she knew right away it was the right resident. V2 said that she reported it right away to the administrator at that time. V2 said that she knows it would have been considered abuse. V2 said the corporate nurse told the current administrator that it is considered abuse. V2 said that she doesn't know any more about it. V2 said that they did do an in-service with staff on the cell phone policy and use. V2 stated she knows that V5 did get terminated for the video. The facility policy Abuse Policy revised 01/09/24 documents in part under abuse policy the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, derivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse neglect exploitation, misappropriation of property, and mistreatment of residents. Definitions documents in part mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment, photography/videotaping/other forms of electronic imaging (See photography Policy), deprivation ($42 CFR 483.12 interpretive guidelines) or observation and/or witness to inappropriate acts displayed by staff or another resident that may be deemed offensive to the resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Photography/Videotaping/Imaging policy revised 03/14/23 documents in part under policy residents will be protected from invasion of privacy and/or abuse that might occur from photographs, videotapes, digital images, and recording during resident care or other facility activities. Policy interpretation and implementation documents in part 2. Staff may not take or release images or recordings of any resident without explicit written consent. Written consent must be obtained from the resident or representative prior to obtaining images or recordings of the resident for any purpose other than investigation of abuse, neglect or emergencies and photography obtained for personal/family use at the verbal request of the resident or family.