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	03/28/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to support resident dignity by the timely answering of call lights for 5 residents (R1, R2, R3, R12, R14) of 14 residents reviewed for dignity in the sample of 14. Findings include: 1. R1's Face Sheet documented an admitted [DATE] and listed Diagnoses including Bipolar Disorder, Chronic Obstructive Pulmonary Disease, and Morbid Obesity with a Body Mass Index of Greater than 70. A Minimum Data Set, dated dated dated [DATE] documented that R1 has minimal deficits in cognition and requires substantial or maximal staff assistance for toileting. R1's Care Plan dated 3/17/25 documented a problem area, (R1) is incontinent of bowel/bladder at times, with corresponding intervention, Check and change during personal care. On 3/21/25 at 1:25pm, R1 was alert and oriented to person, place, and time. R1 stated call lights can take up to an hour to be answered, especially during the evening and night on weekends. R1 stated when staff finally respond, they apologize and explain they are short staffed. R1 stated she needs help with toileting and has had bowel and bladder accidents while waiting on her call light, which she stated were, Humiliating. 2. R2's Face Sheet documented an admitted [DATE] and listed Diagnoses including Left Lower Leg Fracture and Epilepsy. A Minimum Data Set, dated dated dated [DATE] documented that R2 has minimal deficits in cognition and requires substantial/maximal assistance for toileting. R2's Care Plan dated 3/2/25 documented a problem area, Resident is incontinent of bladder, with corresponding intervention, Check and change during personal care. On 3/21/25 at 2:20pm, R2 was alert and oriented to person, place, and time. R2 stated on occasion she has waited over an hour on her call light. R2 stated she has never had a bowel or bladder accident while waiting, but, It's very upsetting and it's hard to hold it that long. 3. R12's Face Sheet documented an admitted [DATE] and listed Diagnoses including Multiple Sclerosis and Diabetes Type 2. A Minimum Data Set, dated dated dated [DATE] documented that R12 has minimal deficits in cognition and is totally dependent on staff for toileting. R12's Care Plan dated 2/8/25 documented a problem area, Resident is incontinent of bowel and bladder related to Multiple Sclerosis, with corresponding intervention, Check and change during personal care. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/25 at 4:00pm, R12 was alert and oriented to person, place, and time. R12 stated she has waited for an hour on her call light while she had on a wet adult brief and needed to be changed. R12 stated, Imagine how it feels when you are left in a wet diaper for an hour. It's not pleasant. 4. R3's Face Sheet documented an admitted [DATE] and listed Diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Diabetes Type 2 and Bipolar Disorder. A Minimum Data Set, dated dated dated [DATE] documented that R3 has no deficits in cognition and is totally dependent on staff for toileting. R3's Care Plan dated 3/17/25 documented a problem area, (R3) has functional bladder incontinence related to impaired Mobility/Cerebral Vascular Accident, with corresponding intervention, (R3) will decrease frequency of urinary incontinence. On 3/22/25 at 6:15am, R3 was alert and oriented to person, place, and time. R3 stated, Sometimes, they don't answer call lights all night long. I've had my call light on for up to 6 hours with no response. After supper you can pretty much forget about getting any help around here. Sometimes, I give up and start yelling for help. The staff don't like it when I do that and they say I am disturbing the other residents. 5. On 3/26/25 at 10:005am, R14 was alert and oriented to person, place, and time. R14 stated on Saturday 3/15/25 after 7pm, his call light was on over 4 hours while he was wanting to be repositioned. R14 stated when staff responded they apologized and said they were short. On 3/27/25 at 10:00am, V2, Director of Nurses, stated it is her expectation that call lights should be answered within a few minutes. V2 stated she was unaware residents were waiting hours on their call light. Resident Council Meeting Minutes documented the following: 3/5/25: Department concerns: Nursing: Call lights. A Resident Rights Policy dated 7/11/22 documented, Policy: Employees shall treat residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to A) A dignified existence. A Call Light Guidance Policy dated 8/20/22 stated, Purpose: To provide guidance to all facility staff on the use, response and placement of call lights. Policy: Resident call light shall be responded to within a reasonable amount of time. Responsibility: It is the responsibility of all staff to respond to call lights.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to provide twice weekly showers for three residents (R3, R12, R14) of 14 residents reviewed for Activities of Daily Living in the sample of 14. Findings include: Resident Council Meeting Minutes documented the following: 1/8/25: Department concerns: Nursing: Showers (not) being done. 2/5/25: Department concerns: Nursing: Showers (not being done). 1. R12's Face Sheet documented an admitted [DATE] and listed Diagnoses including Multiple Sclerosis and Diabetes Type 2. A Minimum Data Set, dated dated dated [DATE] documented that R12 has minimal deficits in cognition and is totally dependent on staff for bathing/showering. R12's March 2025 Shower Documentation showed that R12 did not receive any showers on the weeks of 3/2/25 and 3/16/25. On 3/21/25 at 4:00pm, R12 was alert and oriented to person, place, and time. R12 stated she is not getting her twice weekly showers because the facility is understaffed. 2. R3's Face Sheet documented an admitted [DATE] and listed Diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Diabetes Type 2 and Bipolar Disorder. A Minimum Data Set, dated dated dated [DATE] documented that R3 has no deficits in cognition and is totally dependent on staff for bathing/showering. R3's March 2025 Shower Documentation showed that R3 did not receive any showers in March 2025, having been approached and refused on only two dates, 3/7/25 and 3/11/25. On 3/22/25 at 6:15am, R3 was alert and oriented to person, place, and time. R3 stated, You only get a shower if you kick up a fuss about it. 3. R14's Face Sheet documented an admitted [DATE] and listed Diagnoses including Chronic Obstructive Pulmonary Disease and Diabetes Type 2. A Minimum Data Set, dated dated dated [DATE] documented that R14 has minimal deficits in cognition and requires substantial/maximal assistance from staff for bathing/showering. R14's March 2025 Shower Documentation showed that he refused a shower on 3/20/25, 6 days after admission, and received a shower on 3/24/25. On 3/26/25 at 10:05am, R14 was alert and oriented to person, place, and time. R14 stated he has only had one shower since his admission. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 9:30am, V14, Certified Nursing Assistant (CNA)/Shower Aid, stated residents are to receive at least two showers a week on their scheduled shower days. V14 stated she is frequently pulled from showers to work the floor when they are short. V14 stated when this happens, the CNAs on that hall are expected to do their own showers, and they are not getting done. On 3/27/25 at 10:50am, V15, CNA Supervisor, confirmed that residents are to receive two showers per week. V15 stated she is aware there have been problems with showers not getting done. V15 stated she is going to take V14 off showers and rotate other CNA staff onto showers.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview, and record review, the facility failed to provide narcotic pain medications per physicians orders and failed to assess the effectiveness of non narcotic pain medication for 2 of 2 residents (R1, R3) reviewed for pain management in the sample of 14. This failure lead to R1 and R3 experiencing unrelieved pain up to 9 and 10 on a scale of zero to ten. Findings include: 1. R1's Face Sheet documented an admitted [DATE] and listed Diagnoses including Bipolar Disorder, Chronic Obstructive Pulmonary Disease, and Morbid Obesity with a Body Mass Index of Greater than 70. A Minimum Data Set, dated dated dated [DATE] documented that R1 has minimal deficits in cognition. R1's Care Plan dated 3/17/25 documented a problem area, The resident displays manipulative behavior related to a psychiatric disorder, with corresponding intervention,Educate resident on appropriate means of requesting help for self or others. The Care Plan also documented a problem area, The resident is on pain medication therapy, with corresponding intervention, Administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness every shift. R1's March Physicians Order Sheet (POS) documented orders for lidocaine 4 percent patch apply to bilateral knees topically in the morning, and norco 7.5-325 mg (milligrams). one tablet every 6 hours for pain. R1's March 2025 Medication Administration Record (MAR) documented that R1 did not receive the lidocaine patch on 3/11/25, 3/12/25 and 3/13/25 as it was not available. The same MAR documented that R1 did not receive the norco as it was unavailable from 3/17/25 at 2am until 3/19/25 at 2am, with the exception of one dose given at 2am on 3/18/25. This MAR documented that R1's pain in that time period ranged from 0 to 6, and Tylenol ER 650mg. one tablet every six hours was administered, with no documentation as to the effectiveness. Nurses Notes documented the following: 3/17/25 at 1:53pm: Script for Norco have been faxed to Physicians office to be signed, returned so that they can be forwarded to the pharmacy. 3/17/25 at 2:03pm: Call placed to the pharmacy. There still is not a script for the medication. Waiting on a script. There was no documentation in the Nurses Notes regarding pain levels or effectiveness of the tylenol. On 3/21/25 at 1:25pm, R1 was alert and oriented to person, place, and time. R1 stated earlier in the month she went without narcotic pain medication for two days due to an issue with the pharmacy not delivering it. R1 stated staff gave her tylenol but it was ineffective and her pain was ten on a ten scale during that time. R1 stated in this month there was also a problem with the facility not having received her topical lidocaine patches, which she went without for about 3 days. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2. R3's Face Sheet documented an admitted [DATE] and listed Diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Diabetes Type 2 and Bipolar Disorder. A Minimum Data Set, dated dated dated [DATE] documented that R3 has no deficits in cognition. R3's Care Plan dated 3/17/25 documented a problem area, The resident is on pain medication therapy related to chronic pain,with corresponding intervention, Administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness every shift. R3's March 2025 POS documented orders for tylenol oral tablet 325 mg. give 1 tablet by mouth every 8 hours as needed for pain, and hydrcodone acetaminophen oral tablet 5-325 mg. give 1 tablet by mouth every 6 hours as needed for chronic pain. R3's March 2025 MAR documented that R3 did not receive the hydrocodone on 3/3/25 at 12am and 6am nor on 3/4/25 at 12pm and 6pm, as the medication was unavailable. The same MAR documented that R3's pain in that period ranged from 3 to 9, that tylenol given on 3/4/25 for a pain level of 9 at 11:08am was ineffective, and that tylenol given on 3/4/25 at 6:02pm for a pain level of 9 was effective. Nurses Notes documented the following: 2/28/25 at 3:40pm: Message sent to pharmacy regarding Norco. To be sent with next delivery in morning. 2/28/25 at 6:33pm: Per pharmacy, 3 tablets remaining on script to be sent. Call made to Physician to notify of new script needed. Stated to have pharmacy call. Pharmacy notified and received spoke with Physician per pharmacy message. Message received that Physician has been contacted. On 3/22/25 at 6:15am, R3 was alert and oriented to person, place, and time. R3 stated sometimes his narcotic pain medication is not available because the nurses haven't ordered it. R3 stated he can't recall the level of his pain on a ten scale, but, Its gotten pretty bad. They gave me tylenol, but that didn't really cut it. On 3/27/25 at 10am, V2, Director of Nurses, stated the nurse responsible for passing medication is responsible for reordering the medications when needed. V2 stated if medications are missing, it might be a problem with agency nurses not following through with their responsibilities. V2 stated narcotic pain medications are generally available in the facility's emergency medication kit. V2 stated nursing staff probably accessed some of the doses of R1 and R3's pain medication from the emergency kit although it was not available in the medication cart. A Management of Pain Policy dated 5/16/22 documented, Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. We will achieve these goals through:Using pain medication judiciously to balance the resident's desired level of pain relief with the avoidance of unacceptable adverse consequences.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to provide adequate direct care CNA (Certified Nursing Assistant) staffing. This has the ability to affect all 66 residents living at the facility. Findings include: R1's Face Sheet documented an admitted [DATE] and listed Diagnoses including Bipolar Disorder, Chronic Obstructive Pulmonary Disease, and Morbid Obesity with a Body Mass Index of Greater than 70. A Minimum Data Set, dated dated dated [DATE] documented that R1 has minimal deficits in cognition. On 3/21/25 at 1:25pm, R1 was alert and oriented to person, place, and time. R1 stated call lights take up to an hour because the facility is short staffed, especially from 7pm to 7am throughout the week and on weekends. R12's Face Sheet documented an admitted [DATE] and listed Diagnoses including Multiple Sclerosis and Diabetes Type 2. A Minimum Data Set, dated dated dated [DATE] documented that R12 has minimal deficits in cognition. On 3/21/25 at 4pm, R12 was alert and oriented to person, place, and time. R12 stated there are a lot of CNA (Certified Nursing Assistant) call ins, and she is not getting twice weekly showers because they are understaffed. R12 stated she is sometimes left in a wet adult brief for an hour while her call light is on. R3's Face Sheet documented an admitted [DATE] and listed Diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Diabetes Type 2 and Bipolar Disorder. A Minimum Data Set, dated dated dated [DATE] documented that R3 has no deficits in cognition. On 3/22/25 at 6:15am, R3 was alert and oriented to person, place, and time. R3 stated, Sometimes they don't answer call lights all night long, for up to 6 hours. After supper you can pretty much forget about getting any help. They always say they are sorry, but they're short. On 3/26/25 at 10:05am, R14 was alert and oriented to person, place, and time. R14 stated on Saturday 3/15/25 after 7pm, his call light was on over 4 hours while he was wanting to be repositioned. R14 stated when staff responded they apologized and said they were short. On 3/26/25 at 8:25am, V10, CNA, stated there are lots of call ins on the 2pm-10pm shift especially on weekends. On 3/26/25 at 9:20am, V9, CNA, stated on Sunday 3/23/25, the 10pm-6am shift, which is to have at minimum 4 CNAs, only had 2 due to call ins. On 3/26/25 at 11:15am, V7, CNA, stated when she came in Monday 3/24/25, there were only 2 CNAs working the 10pm to 6am shift. V7 stated there were residents wearing two completely soaked adult briefs and most incontinent residents beds had to be completely stripped. V7 stated when staff complain to management, they are told they are not allowed to have more staff according to the census numbers. V7 stated there are frequently no CNAs assigned to A Hall, and CNAs on B and C Halls are told to, Take turns watching A Hall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/26/25 at 1:45pm, V6, CNA, stated she and one other CNA and two nurses were the only staff in the building on 3/23/25 from 10pm to 6am. V6 stated they did the best they could but the reports from day shift about residents being soaked through is probably accurate. V6 stated they are to have 4 CNAs on the 10pm to 6am shift, but they have worked with only 3 several times. V6 stated no CNA's are assigned to A Hall anymore, and CNAs on the other halls are to, Take turns splitting it. On 3/26/25 at 2:30pm, V8, CNA, stated she works on a prn (as needed) basis, and she has worked all shifts on all halls, every day of the week. V8 stated management waits too late to get coverage when there are call ins. V8 stated residents have told her they try not to use their call lights because they know the CNAs are working short. V8 stated the facility's pay and benefit package are not competitive with nearby facilities. V8 stated she has worked at the facility over three years and has not received annual pay raises as she should have. On 3/27/25 at 7:40am, V17, Minimum Data Set Coordinator, stated she is at present the staff member responsible for scheduling CNA and nursing staff, although moving forward it will not be part of her duties. V17 stated they, Try to schedule 6 CNAs on the 6am to 2pm shift, with a Shower Aid Monday though Friday. V17 stated the Shower Aid does get pulled to the floor sometimes and CNA's have to do their own showers. V17 stated on the 2pm to 10pm shift, they are to have a minimum of 6 CNAs, and on the 10pm to 6am shift they schedule 4. V17 stated A Hall is split by the CNA's on B and C Halls, and the two nurses each take B or C Hall and one side of A Hall. When asked how effective the A Hall coverage is, V17 stated when CNA's are at the nurses station charting, they can easily see call lights going off on A Hall and respond if needed. V17 stated on Monday 3/24/25 she saw where there had only been 2 CNAs on the 10pm to 6am shift. V17 stated as the management staff covering that evening, V12, Assistant Director of Nurses, should have come in and worked if he could not find coverage. On 3/27/25 at 8:30am, V1, Administrator, stated the facility is always trying to hire more CNA staff. V1 stated the facility's pay and benefits are highly competitive compared with other facilities in the community. On 3/27/25 at 8:50am, V12, Assistant Director of Nurses, stated on 3/23/25 the 10pm to 6am shift, there were 2 CNA call ins and one no call no show. V12 stated he tried to find coverage, including agency staff, but was unable. V12 stated he did not come in to cover the shift as it is his understanding that is the responsibility of V15, CNA Supervisor. On 3/27/25 at 9:30am, V14, CNA/Shower Aid, stated she is frequently pulled from showers onto the floor due to call ins. On 3/27/25 at 10am, V2, Director of Nurses, stated she feels CNA pay and benefits are competitive as far as she knows. V2 stated on 3/23/25, V15 should have come in and covered the 10pm-6am shift, and she is not sure not sure why she didn't . On 3/27/25 at 10:50am, V15 stated on 3/24/25 she woke up in the morning to realize when reading the facility group chat that they had needed CNA coverage for the previous 10pm-6am shift. V15 stated she had been asleep when the chat was taking place. On 3/27/25 at 12:25pm, V18, CNA, stated working conditions at the facility are not good due to being constantly short staffed and pay and benefits not being competitive. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident Council Meeting Minutes documented the following: 1/8/25: Department concerns: Nursing: Showers (not) being done. 2/5/25: Department concerns: Nursing: Showers (not being done). 3/5/25: Department concerns: Nursing: Call lights. A March 2025 Schedule documented that on 3/3/25, there were 3 CNAs working the 10pm to 6am shift; On 3/12/25, 3/12/25, and 3/14/25. This schedule documented that on 3/23/25, there were 2 CNAs working the 10pm to 6am shift. On all these dates, there was no CNA coverage assigned to the A Hall. The facility's Staffing Policy dated 6/13/23 stated, Purpose: To offer guidance to the facility on employee staffing. Policy: The facility has developed and assigned duty hours for the Nursing Services department, based on state/federal requirements and utilizing the staffing calculator. Policy Interpretation and Implementation: 1. Nursing service is provided twenty-four (24) hours per day, seven days per week. 2. Staggered work hours may be assigned by the Director of Nursing Services when necessary. 3. Departmental work schedules may be revised by the Director of Nursing Services when deemed necessary and appropriate to ensure that each resident's needs are met. A Facility Matrix dated 3/21/25 documented a total of 66 residents living at the facility.

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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** 32619 Based on observation, interview, and record review, the facility failed to provide medications per physicians orders for three residents (R1, R3, R11) of 14 residents reviewed for medication orders in the sample of 14. Findings include: 1. R11's Face Sheet documented an admitted [DATE] and listed Diagnoses including Diabetes Type 2 and Unspecified Psychosis. R11's Minimum Data Set, dated dated dated [DATE] documented that R11 has severe deficits in cognition. R11's March 2023 Physicians Orders Sheet (POS) documented an order for benztropine 0.5 milligrams (mg) twice daily. On 3/21/25 at 7:45am, V3, Registered Nurse, was observed passing medications to 200 Hall residents. V3 prepared R11's 8:00am medications, and there was no benztropine in the cart for R11. V3 stated she was not sure why the medication was not in the cart. V3 stated the nurses are responsible for ordering the medications for residents on their hall. V3 stated she would order the medication but it would probably not arrive until tomorrow. R11's March 2025 Medication Administration Record (MAR) documented that the benztropine was not administrated on 3/21/25 as it was not available. 2. R1's Face Sheet documented an admitted [DATE] and listed Diagnoses including Bipolar Disorder, Chronic Obstructive Pulmonary Disease, and Morbid Obesity with a Body Mass Index of Greater than 70. A Minimum Data Set, dated dated dated [DATE] documented that R1 has minimal deficits in cognition. R1's March 2025 POS documented orders for lidocaine 4 percent patch apply to bilateral knees topically in the morning, and norco 7.5-325 mg. one tablet every 6 hours for pain. R1's March MAR documented that R1 did not receive the lidocaine patch on 3/11/25, 3/12/25 and 3/13/25 as it was not available. The same MAR documented that R1 did not receive the norco as it was unavailable from 3/17/25 at 2am until 3/19/25 at 2am, with the exception of one dose at 2am on 3/18/25. Nurses Notes documented the following: 3/17/25 at 1:53pm: Script for Norco have been faxed to Physicians office to be signed, returned so that they can be forwarded to the pharmacy. 3/17/25 at 2:03pm: Call placed to the pharmacy. there still is not a script for the medication. Waiting on a script. There was no documentation in the Nurses Notes regarding pain levels or effectiveness of the tylenol. (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	03/28/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/25 at 1:25pm, R1 was alert and oriented to person, place, and time. R1 stated earlier in the month she went without narcotic pain medication for two days due to an issue with the pharmacy not delivering it. R1 stated staff gave her tylenol but it was ineffective and her pain was ten on a ten scale during that time. R1 stated in this month there was also a problem with the facility not having received her topical lidocaine patches, which she went without for about 3 days. 3. R3's Face Sheet documented an admitted [DATE] and listed Diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Diabetes Type 2 and Bipolar Disorder. A Minimum Data Set, dated dated dated [DATE] documented that R3 has no deficits in cognition and is totally dependent on staff for toileting. R3's March POS documented orders for tylenol oral tablet 325 mg. give 1 tablet by mouth every 8 hours as needed for pain, and hydrcodone acetaminophen oral tablet 5-325 mg. give 1 tablet by mouth every 6 hours as needed for chronic pain. R3's March 2025 MAR documented that R3 did not receive the hydrocodone on 3/3/25 at 12am and 6am and 3/4/25 at 12pm and 6pm as the medication was unavailable. Nurses Notes documented the following: 2/28/25 at 3:40pm: Message sent to pharmacy regarding Norco. To be sent with next delivery in morning. 2/28/25 at 6:33pm: Per pharmacy, 3 tablets remaining on script to be sent. Call made to Physician to notify of new script needed. Stated to have pharmacy call. Pharmacy notified and received spoke with Physician per pharmacy message. Message received that Physician has been contacted. On 3/22/25 at 6:15am, R3 was alert and oriented to person, place, and time. R3 stated sometimes his narcotic pain medication is not available because the nurses haven't ordered it. On 3/27/25 at 10am, V2, Director of Nurses, stated the nurse responsible for passing medication is responsible for reordering the medications when needed. V2 stated if medications are missing, it might be a problem with agency nurses not following through with their responsibilities. V2 stated narcotic pain medications are generally available in the facility's emergency medication kit. V2 stated nursing staff probably accessed some of the doses of R1 and R3's pain medication from the emergency kit although it was not available in the medication cart. A Medication Administration Policy/Procedure dated 9/27/22 documented, Purpose: To ensure proper administration of oral medications. Policy: Medications will be administered safely to residents within the facility by licensed nurses at the specified time/timeframe, following the recommended administration method and will be documented as required.