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	06/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's representative of a hospital admission for 1 (R1) of 3 residents reviewed for notification of changes in the sample of 8. Findings include: R1's admission Record documents an admission date of 03/06/25 and includes diagnoses of encounter for orthopedic aftercare following surgical amputation, type 2 diabetes mellitus with diabetic neuropathy, unspecified; unspecified severe protein-calorie malnutrition; osteomyelitis, unspecified; local infection of the skin and subcutaneous tissue. R1's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 6, indicating that R1 has severe cognitive impairment. On 06/03/25 at 10:24am, V2 (Director of Nursing/DON) stated R1 had an appointment with Podiatry on 05/29/25 and they scheduled him for a debridement the next morning. V2 stated they were waiting on the preauthorization for R1's procedure. V2 stated on 05/30/25 when they took R1 to the hospital for the procedure they did not have the authorization for the procedure and they sent him to the ER (Emergency Room). V2 stated R1 was a direct admit from the ER and he had the procedure inpatient. V2 stated she was not sure what R1's BIMS score was, but confirmed he was listed as financial responsible party and his wife was listed as his first emergency contact, not POA (Power of Attorney). V2 stated if someone was cognitively intact and did not have a POA or responsible party it would be up to the resident if they contacted family or not, if they were not cognitively intact, family should be contacted. On 06/03/25 at 12:08pm, V3 (Family Member) stated she was not aware that R1 was hospitalized until a Social Worker from the hospital called and left a message about where to send her husband to. V3 stated she called them back and was all but arguing with the hospital because she had no knowledge of R1 being hospitalized . V3 stated she had received a picture of R1's foot the night before and it looked good, she stated she could hardly believe that he needed surgery on it. V3 stated she was not even informed R1 was scheduled for the outpatient debridement on 05/30/25. V3 stated that R1 on his best days has a BIMS of maybe a 4. V3 stated that she is R1's POA and designated R1's son as his emergency contact #1. V3 stated she filled out the POA paperwork at the facility. V3 stated she has yet to hear anything from the facility about R1. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/03/25 at 12:39pm, V2 (DON) stated that residents who have a BIMS score of 6 or 7 should have a Power of Attorney (POA) in place. V2 stated in a perfect world R1's family should have been notified as soon as they found out he was going to be admitted to the hospital. On 06/03/25 at 12:40pm, V4 (Corporate Nurse) stated a resident should have a BIMS of 12 or above to be able to be their own representative. On 06/03/25 at 12:42pm, V5 (Social Service Director/SSD) stated she knew that R1's wife had filled out POA paperwork and she would locate it. On 06/23/25 at 1:26pm, V5 (SSD) stated she had not filed R1's POA paperwork was because his wife had requested that one of his sons also be POA because of her health problems. V5 stated R1's son had not returned their calls. On 06/03/25 at 2:25pm, V6 (Transportation/Certified Nurse Aide/CNA) stated it was her understanding on Thursday 5/29/25 that R1 was having a procedure the next morning at the procedure center. V6 stated that when she left work that evening, she was instructed to call before they left the next morning to ensure the doctor had secured approval from insurance. V6 stated she called around 6:30am and was informed that they did not have the authorization yet, to call back in 30-45 minutes. She stated she called back, and they still had not received it, to stand by and they were calling the doctor. V6 stated shortly after someone at the facility told her to take R1 to the emergency room per the procedure center. V6 stated they loaded R1 up and the other transportation aide drove him in the van, and she followed in her personal vehicle so she could sit with him, and the van could be utilized for other already scheduled appointments. V6 stated she heard the ER staff talking about R1 being a direct admit amongst themselves, but no one had notified her of this. V6 stated finally she questioned them about it and they said, we are admitting R1 to the hospital. V6 stated she went back to the facility and went right into the morning meeting and let everyone know what was happening with R1. V6 stated she knows R1's family personally and would have let them know had she not had such a busy day and all the confusion. V6 stated it is technically not a part of her job responsibilities to notify family, someone who is a nurse should be notifying them, in case there are questions. On 06/03/25 at 2:42pm, V7 (Transport CNA) stated it is not their responsibility to notify family in these situations. V7 stated R1 is still hospitalized , and they have not been able to get a clear picture of what is going on with him. On 06/03/25 at 2:51pm, V2 (DON) confirmed it is not the responsibility of the transportation aide to inform the family that a resident is admitted to the hospital. A facility document titled Power of Attorney for Health Care signed by R1 on 03/07/25 and witnessed by V5 (SSD) on 03/07/25 documents R1's wishes that V3 (Family Member) be his healthcare agent. R1's admission Record documents that R1 is the financial responsible party and V3 is listed as emergency contact #1. There is no Power of Attorney, or any other responsible party listed on this document. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility document titled Notice of Transfer or Discharge signed on 06/03/25 found in R1's electronic medical record, documents that R1 was discharged on 05/30/25 per physician's orders. The facility was unable to provide any reproducible evidence that V3 was contacted regarding R1's procedure or hospitalization on 05/30/25. The facility policy titled Discharge/Transfer Policy with a revision date of 08/15/22 documents under the section procedure: when the facility transfers or discharges a resident under any circumstances .appropriate documentation shall be make in the resident's clinical record.