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	07/11/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 1 (R4) of 3 residents reviewed for abuse in the sample of 5. R4's admission Record documents that R4 was admitted to the facility on [DATE]. Diagnoses listed are vascular dementia, type 2 diabetes mellitus, brief psychotic disorder, unspecified mood disorder, auditory hallucinations, schizophrenia, anxiety and unspecified psychosis. R4's MDS (Minimum Data Set) dated 03/26/2025, documents R4 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R4 is cognitively intact. R4's Care Plan with a revision date of 07/08/2025 has a focus are of, (R4) is at risk for decline in psychosocial well being related to: Allegation of abuse related to a resident-to-resident altercation. The interventions listed are: provide 1:1 visit, and staff educated to keep residents separated. R5's admission Record documents that R5 was admitted to the facility on [DATE]. Diagnoses listed are acute respiratory failure, chronic obstructive pulmonary disease, chronic combines systolic and diastolic heart failure, anxiety, essential hypertension, and Alzheimer's Dementia. R5's MDS dated [DATE], documents under section C0100. Should the Brief Interview for Mental Status be conducted? 0. No resident is rarely / never understood. R5's Care Plan with a revision date of 04/02/2024 has a focus area of, (R5) is/has potential to be physically aggressive related to dementia. The interventions listed for this area are administer medications as ordered. Document / monitor for side effects and effectiveness. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior, assess and anticipate residents needs: food, thirst, toileting, comfort level and pain, when the resident becomes agitated intervene before it escalates, guide away from distress, engage in calm conversation.A Verification of Incident Investigation / Administrative Summary documented on 05/27/2025 at 8:30 P.M. R4 and R5 were both out in the common area sitting in their wheelchairs when R5 reached over and made contact with R4 in the neck area. Staff immediately separated residents moving them to different areas allowing time to calm down. Nurse assessed with no injuries noted. Administrator reinterviewed both residents, neither remembered the incident. Other residents were interviewed with no negative findings. Staff were interviewed with no negative findings. Neither resident show any negative psychosocial affects related to incident and continue their normal daily routine. There was no documentation in the Nurse's Notes of R4 or R5's medical records to describe the resident-to-resident altercation. On 07/09/2025 at 1:15 P.M. V1 (Administrator) stated she was not working at the facility when the resident-to-resident altercation occurred. V1 stated that what she can tell from the investigation, R4 and R5 was in the common area and R5 struck R4. V1 stated there were no injuries documented. On 07/09/2025 at 1:37 P.M. V2 (Director of Nursing) stated he is not aware of the resident-to-resident altercation that occurred in May 2025 between R4 and R5. V2 stated the previous administrator would not share any information about those situations with him. V2 stated he is not aware of any new interventions that were put into place to prevent a new altercation.On 07/08/2025 at 3:52 P.M. V6 (Family Member) stated R4 and R5 had a resident-to-resident altercation in May 2025, and she cannot remember the exact date. V6 stated that she was not made aware of the outcome of the resident to resident altercation and believes the facility should provide 1:1 monitoring of R5 to prevent any further altercations from occurring. The facility policy titled Abuse Policy with a revision date of 01/09/2024 documented under section titled 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 management. Under section titled Abuse Policy The purpose of this policy is to assure that the facility is doing all hat 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.

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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. (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 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide narcotic pain medications per physician's orders for 1 (R1) of 3 residents reviewed for pain management in the sample of 5. This failure resulted in R1 experiencing unrelieved pain and having to be sent to the local hospital for treatment of pain. R1's admission Record documents that R1 is a [AGE] year-old that was admitted to the facility on [DATE]. Diagnoses included are unspecified fracture of right femur, cirrhosis of liver, pain due to internal orthopedic prosthetic device, pain in right hip, weakness, chronic kidney disease, anemia, and osteoarthritis of right knee. R1's MDS (Minimum Data Set) dated 06/16/2025, documented that R1 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R1 is cognitively intact. R1's Care Plan with a revision date of 09/30/2024 has a focus are of The resident has chronic pain. Interventions listed are administer analgesia as per orders, anticipate the resident's need for pain relief and respond to any complaint of pain, monitor/record/report to nurse any signs and symptoms of nonverbal pain, monitor / document for probable cause of each pain episode, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past, and monitor / record/ report to Nurse resident complaints of pain or requests for pain treatment. R1's Order Summary with a print date of 07/02/2025 document an order for hydrocodone -acetaminophen 7.5 mg - 325 mg by mouth every 4 hours as needed for moderate pain with an order date 06/10/2025 and an order for hydrocodone - acetaminophen 5-325 mg by mouth every 6 hours as needed for pain with an order date of 06/19/2025. Both orders were documented as being active.R1's June 2025 Medication Administration Record (MAR) documented that R1 received hydrocodone - acetaminophen 7.5 - 325 mg on 06/24/2025 at 12:28 P.M. with a pain level of 7. R1 did not receive another dose until 06/26/2025 at 5:11 P.M. with a documented pain level of 10. There is no charted effectiveness for either date. R1's Progress Notes dated 06/25/2025 at 11:20 P.M. document R1 woke up crying in pain stating her pain level was a 12, currently no pain medication on unit, awaiting refill at pharmacy signed by physician. Requesting to go to local hospital for pain management.R1's Progress Notes dated 06/26/2025 at 4:15 A.M. document Resident back on unit via ambulance company. Paper prescription received for Norco (hydrocodone - acetaminophen) 7.5 mg -325 mg, 8 tablets. Resident in bed stating she was in no pain.The local hospital ED Provider Note dated 06/26/2025 1:25 A.M. documented that R1 is at a nursing facility and apparently was controlled with Norco. However, she says that the nursing home ran out this am, and her last dose was 06/25/2025 at 11:00 A.M. She states she feels the pain is due to not being able to take any medications. I guess patient has pain medication but ran out now has pain, so I guess that is what I am treating, so gave some IM (Intramuscular) fentanyl. So, plan to discharge back. Nursing home is asking us to write a prescription for the Norco, I don't have a problem with writing it, but in theory the prescription for narcotics has to be done electronically, and patient has to pick it up. Who picks up the prescription (paper electronic or otherwise) so not sure how the prescription will be honored. I guess it also begs the question, if I can just write a paper prescription for the Norco then why didn't they just call the primary care physician and have her do it? So, I am writing the prescription as a way to help out but its not how the pharmacies usually want a narcotic prescription.R1's June 2025 MAR documented that R1 received hydrocodone - acetaminophen 5-325 mg on 06/29/2025 at 11:41 A.M. with pain level rated at a 10. There is no documentation of R1 receiving another dose until 6/30/25 at 10:00 A.M. with a pain level rated at a 7. R1's Progress Notes dated 06/29/2025 at 2:02 P.M. document Resident is crying due to pain in her right hip and leg. Surgical incisions have no apparent signs / symptoms of infection. Resident is requesting to go to the hospital to get evaluated. Call was placed to physician to make aware and ok'd sending her out for evaluation and treatment as indicated.R1's Progress Notes dated 06/29/2025 at 2:15 P.M. document Resident left the facility per ambulance to go to local hospital. This nurse placed another call to physician regarding having the pharmacy call her for a pain medication refill. Spoke to pharmacy, medication would arrive tonight with the delivery. And a code (to utilize back up supply) be obtained if needed. At 2:26 P.M. this nurse spoke to the local emergency department charge nurse regarding a local prescription that the facility could obtain until the delivery arrives. Pain medications were picked up from local pharmacy by staff.The local hospital ED Provider Note dated 06/29/2025 documented that R1 presents to the emergency department for pain management. R1 has been out of Norco for a few days. On 07/02/2025 at 2:51 P.M., R1was alert and orientated to person, place and time, stated she has gone to the hospital twice recently because the facility

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain a new prescription for a controlled substance in a timely manner for 1 of 3 residents (R1) reviewed for pharmacy services in the sample of 5.R1's admission Record documents that R1 is a [AGE] year-old that was admitted to the facility on [DATE]. Diagnoses included are unspecified fracture of right femur, cirrhosis of liver, pain die to internal orthopedic prosthetic device, pain in right hip, weakness, chronic kidney disease, anemia, and osteoarthritis of right knee. R1's MDS (Minimum Data Set) dated 06/16/2025, documented that R1 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R1 is cognitively intact. R1's Care Plan with a revision date of 09/30/2024 has a focus are of The resident has chronic pain. Interventions listed are administer analgesia as per orders, anticipate the resident's need for pain relief and respond to any complaint of pain, monitor/record/report to nurse any signs and symptoms of non - verbal pain, monitor / document for probable cause of each pain episode, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past, and monitor / record/ report to Nurse resident complaints of pain or requests for pain treatment. R1's Order Summary with a print date of 07/02/2025 document an order for hydrocodone -acetaminophen 7.5 mg - 325 mg by mouth every 4 hours as needed for moderate pain with an order date 06/10/2025 and an order for hydrocodone - acetaminophen 5-325 mg by mouth every 6 hours as needed for pain with an order date of 06/19/2025. Both orders were documented as being active.R1's Progress Note dated 06/25/2025, with a time of 11:20 P.M. documented that R1 woke up crying in pain stating her pain level was a 12, currently no pain medication on unit. Requesting to go to local hospital for pain management. R1's Progress Note dated 06/29/2025, with a time of 2:02 P.M. documented that R1 was crying due to pain in her right hip and leg. R1 is requesting to go to the hospital for treatment.R1's Progress Note dated 06/29/2025, with a time of 2:15P.M. documented that V3 (Registered Nurse) placed call to V9 (Physician) to obtain a refill on R1's pain medication. R1's Progress Note dated 06/29/2025, with a time of 2:26 P.M. documented that V3 spoke with the local hospital and asked if the hospital could send a prescription to a local pharmacy because R1's medication would not be at the facility from the pharmacy until later that night. Pain medication was picked up by facility staff from local pharmacy.On 07/02/2025 at 2:51 P.M. R1 stated she has gone to the hospital twice recently because the facility did not have her pain medication. R1 stated she is not sure why the facility was running out of her medications. R1 stated the ride in the ambulance to the hospital was horrific. R1 stated that she had hip surgery in June. R1 stated that she needs her pain medication because she can't stand the pain. On 07/09/2025 at 1:15 P.M. V1 (Administrator) stated that she was not notified about R1 having to be sent to the hospital for pain control until after it had occurred. V1 stated there should not be a time that the facility does not have medications for a resident. V1 stated the only way to ensure that the resident received pain medications was to have the emergency department send the prescription to a local pharmacy and have a staff member pick it up. V1 stated that the nurses are to check narcotics in the middle of the week to see if they have any that need refills or a new prescription to prevent residents from running out.On 07/08/2025 at 9:43 A.M. V2 (Director of Nursing) stated when a resident has a script that runs out, the nurse should call the doctor and get a new prescription for the medication. If it is after hours or a weekend, V2 stated the pharmacy can call the doctor on call and obtain the prescription. V2 stated that if the resident has an active prescription for a medication, they can get it out of the backup medication kit. V2 stated that R1 was without her medication and the nurse sent her out twice. V2 stated the resident did have the last prescription filled from a local pharmacy to ensure that she did not have to go back to the emergency department. V2 stated that the prescription was not asked in enough time that R1 would not run out of medications. V2 stated he would expect for the nurses to make sure that a resident does not run out of pain medications. V2 stated now they are looking at the narcotic cards on Wednesday or Thursday of each week to see if anyone needs a refill or a new prescription before the weekend to prevent them from running out of medications. V2 stated on Fridays the nurses are to check to make sure what was ordered came in. On 07/02/2025 at 2:40 P.M. V3 (Registered Nurse) stated the first time that R1 went to the hospital she was sent back with a script for 8 pills. V3 stated that when residents come back from the hospital with scripts, the facility will fax it to the pharmacy. V3 stated she does not know why the pharmacy does not fill the medications when they receive a script. V3 stated the day she sent R1 to the hospital, she was out of medication, and she did not know when the pharmacy would deliver it. V3 stated that she told the hospital

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident received the correct medications in accordance with their physician's orders for 1 (R4) of 3 residents reviewed for medications in the sample of 5. This failure resulted in R4 having increased behaviors and being hospitalized for behaviors. R4's admission Record documents that R4 was admitted to the facility on [DATE]. Diagnoses listed are vascular dementia, type 2 diabetes mellitus, brief psychotic disorder, unspecified mood disorder, auditory hallucinations, schizophrenia, anxiety and unspecified psychosis.R4's MDS (Minimum Data Set) dated 03/26/2025, documents R4 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R4 is cognitively intact.R4's Care Plan with a revision date of 5/7/24 documents a Focus area of This resident is on an antipsychotic. Documented interventions include: Administer medication as directed by physician. R4's Order Listing Report dated 07/10/2025 documented an order for Haloperidol Decanoate Intramuscular Solution (Haldol) 100 milligram (mg)/milliliter (mL) Inject 1.5 mL intramuscularly every 28 days for agitation related to bipolar disorder with a start date of 06/27/2025 and an order status of active. R4's Order Listing Report documented the same order dated 09/05/2023 with a revision date of 06/27/2025 and an order status of discontinued.'R4's May 2025 Medication Administration Record (MAR) on 05/14/2025 documented MN for the Haloperidol injection. R4's June 2025 MAR on 06/11/2025 documented MN for the Haloperidol injection. The chart code on the MAR documented that MN meant medication not available.R4's Progress Note dated 06/01/2025 at 7:27 P.M. documents that R4 became belligerent. R4 threw two books and a remote control at a resident. R4 continued yelling and threatening. R4 shoved her wheelchair at a resident and staff member missing them. R4's wheelchair hit the medication cart. R4 turned to run back to her room slipping and falling. R4 continued to be belligerent laying on floor. Notified physician of behaviors and received order to send to the hospital. R4 continued making threats to staff including I want to shoot you in the head.R4's Progress Note dated 06/02/2025 with a time of 9:10 A.M. documents R4 verbally aggressive towards staff and attempted to hit another resident. While R4 was in her room she placed wheelchair in front of door was screaming and yelling at staff that she would hurt herself and others. R4 sent to the local hospital for evaluation.R4's Progress Note dated 06/02/2025 with a time of 3:48 P.M. documents R4 has been verbally aggressive on multiple occasions, observed swinging her fists at staff and other residents. R4 was kicking the medication cart when nurse tried to go past R4. Attempted to calm multiple times with no change in behavior. While in room, R4 can be heard throwing items and slamming doors.R4's Progress Note dated 06/03/2025 with a time of 9:25 A.M. documents R4 was admitted to behavioral health with diagnosis of aggressive behavior. R4's Progress Note dated 06/18/2025 with a time of 1:50 P.M. documents R4 was threatening suicide with plans to staff, call placed to physician, R4 sent to the local hospital for evaluation and treatment. R4's Progress Note dated 07/02/2025 with a time of 12:36 A.M. documents R4 sitting on side of bed stating she hears voices in her head. R4 pushed her walker against the wall and wheelchair to the other side of the room.R4's Progress Note dated 07/07/2025 with a time of 11:48 P.M. documents attempted to notify physician of missed injections. Message left to return call.The Emergency Department Note from the local hospital dated 06/02/2025 documented R4 is a [AGE] year-old female who presents to the emergency department this evening from local facility due to concern for behavioral health issues. Patient does have a known history of dementia and schizophrenia and per report, has been very aggressive toward staff and residents at facility. R4 was seen at our facility a few days ago after sustaining a fall while getting in an altercation with some of the staff and residents they are where she was throwing books at them and trying to hit them with her wheelchair. R4 admits that she has been very verbally aggressive with them as she got really agitated at them. R4 admits that she is hearing voices and says that she has been taking her psych meds regularly. Denies any active suicidal or homicidal plans. R4 was evaluated by our central intake team recommending inpatient voluntary psychiatric admission for unspecified mood disorder.The Behavioral Health Note from the local hospital dated 06/06/25025 documented R4 was admitted voluntarily from local emergency department who presents with worsening depression and with psychosis, inability to keep themselves safe, and inability to keep others safe reports passive homicidal ideation. R4 was monitored in emergency department until medically cleared and transferred to the unit for observation and was placed on suicidal precautions. R4 was provided inpatient psychiatric treatment with Face to Face Interaction, Medication Review & Management, safe and supportive environment, group therapy, individual counseling