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	11/14/2025

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 - Immediate jeopardy to resident health or safety 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. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the physician for a resident's change in condition for 1 of 3 residents (R1) reviewed for changes in condition in a sample of 13. This failure resulted in R1's hospitalization for sepsis and subsequent death.This failure resulted in an Immediate Jeopardy, which was identified to have begun on 10/5/25 when the facility staff failed to notify the physician that R1 had decreased urine output and oral intake, was refusing to eat, and appeared lethargic. On 10/7/25, R1 was found to have a worsened pressure ulcer and a sharp decline in R1's overall condition and was sent to the ER (Emergency Room). R1 expired on 10/8/25 with a cause of death of Sepsis. The findings include: R1's Face Sheet documented an admission Date of 3/3/22 and listed Diagnoses including Asthma, Peripheral Vascular Disease, Hypothyroidism, Bipolar Disorder, Hypertension, and Diabetes Type 2. R1's Minimum Data Set, dated [DATE] documented that R1 was severely cognitively impaired, had an indwelling catheter, and was totally dependent on staff for eating, showering, toileting, and transfers. An October 2025 Wound Log documented that R1 had a stage 4 pressure wound to the sacrum and a stage 4 pressure area to the right heel. R1's Care Plan dated 9/17/25 documented problem areas, Resident is a full code, and, Resident has impaired skin integrity as evidenced by right heel arterial ulcer, sacrum pressure ulcer related to impaired cognition, incontinent of bowel, poor nutritional intake, with a corresponding intervention, Notify Physician/Nurse Practitioner/Physician's Assistant of signs/symptoms of infection(new or change in type/amount/color of drainage, bleeding, foul odor) . R1's October 2025 Physicians Orders Sheet (POS) documented orders for a daily skin check using the CROPS method (Clear Red Open Pressure Skin Tear), daily foot check, contact Isolation for ESBL (Extended-Spectrum Beta-Lactamase) in the urine, and (trade name) indwelling catheter, (check) output two times a day. This same POS documented treatment orders as follows:Non pressure chronic ulcer of the right heel: Cleanse with normal saline, apply Medihoney, apply bordered gauze, (change) every Tuesday, Thursday, Saturday, and as needed, order date 9/24/25.Pressure ulcer to Sacrum: Cleanse with wound cleanser, apply collagen hydrogel, collagen particles, silver sulfadene, and calcium alginate to base of the wound, change every Tuesday, Thursday, and Saturday and as needed, order date 9/24/25.R1's October 2025 Treatment Administration Record (TAR) documented the above wound treatment orders, with a blank space for day shift 10/4/25, indicating the treatments to the wounds of the sacrum and right heel had not been done. R1's October 2025 Follow Up Questions Report, Fluid Intake, Catheter Output, and Eating and Amount Eaten, (CNA output charting) and October 2025 TAR (Nurse output charting) documented the following total urine outputs:10/1/25: 720cc (cubic centimeters). 10/2/25: 775cc. 10/3/25: 940cc. 10/4/25: 240cc. 10/5/25:1775cc. 10/6/25: 1920cc.R1's October 2025 Follow Up Questions Report, Fluid Intake, Catheter Output, and Eating and Amount eaten documented the following meal and fluid intakes:10/1/25: Breakfast: 0-25% (percent) Lunch: 0-25%. Supper-blank, not documented. Fluids total 720cc.10/2/25: Breakfast: 76-100%. Lunch 76-100%. Supper-blank, not documented. Daily fluid total: Blank, not documented.10/3/25: Breakfast: 76-100%. Lunch: 76-100%. Supper-blank, not documented. Daily fluid total: 940cc.10/4/25: Breakfast: 26-50%. Lunch and supper: Blank, not documented. Daily fluid intake total: 240cc.10/5/25: Breakfast, lunch, and supper refused. Daily fluid intake total: 1300cc.10/6/25: No documentation on any meals. Daily fluid intake total:120cc.R1's Wound Assessment Reports, authored by V4 (Wound Care Nurse Practitioner) documented the following:9/30/25: Stage 4 pressure area, sacrum: Facility acquired: No. Wound status: Improving with delayed wound closure. Length: 9.00 cm (centimeters), Width: 9.00 cm long by width: 81.00 cm, 2 Depth: 6.00 cm. 70% granulation (tissue), 30% slough. Undermining: from 6 o'clock to 9 o'clock, 6.0 cm. Heavy seropurulent drainage. Odor post cleansing: Malodorous. Arterial ulcer right heel: Acquired in facility: Yes. Wound status: Improving with delayed wound closure. Moderate amount of seropurulent drainage. Odor post cleansing: None. % Granulation: 50% granulation % Slough: 30% slough % Eschar: 20% eschar.10/7/23: Stage 4 pressure area, sacrum: Facility acquired: No. Wound status: Worsening. Length: 9.00 cm Width: 12.00 cm long by width: 108.00 cm. 2 Depth: 6.00 cm.0% Granulation, 100% slough. Undermining: from 6 o'clock to 9 o'clock, 6.0 cm. Heavy amount seropurulent drainage. Odor post cleansing: Malodorous. Arterial ulcer right heel. Acquired in facility: Yes. Wound status: Improving with delayed closure. Moderate amount of seropurulent drainage. Odor post cleansing: None. % Granulation: 50% granulation % Slough: 30% slough % Eschar: 20% eschar. R1's Nursing Progress note dated 10/7/25 at 10:42am, authored by V3 (Registered Nurse/RN) documented:

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to recognize and assess the symptoms of a worsened pressure wound and provide and document wound treatments as ordered for 2 of 3 residents (R1, R3) reviewed for pressure ulcers in the sample of 13. This failure resulted in R1's sacral ulcer worsening and R1 being transferred to the hospital, where the wound was found to be infected with gram positive cocci and gram-negative bacilli.The findings include:1. R1's Face Sheet documented an admission Date of 3/3/22 and listed Diagnoses including Asthma, Peripheral Vascular Disease, Hypothyroidism, Bipolar Disorder, Hypertension, and Diabetes Type 2. R1's Minimum Data Set, dated [DATE] documented that R1 was severely cognitively impaired, had an indwelling catheter, and was totally dependent on staff for eating, showering, toileting, and transfers. An October 2025 Wound Log documented that R1 had a stage 4 pressure wound to the sacrum and a stage 4 pressure area to the right heel. R1's Care Plan dated 9/17/25 documented problem areas, Resident is a full code, and, Resident has impaired skin integrity as evidenced by right heel arterial ulcer, sacrum pressure ulcer related to impaired cognition, incontinent of bowel, poor nutritional intake, with a corresponding intervention, Notify Physician/Nurse Practitioner/Physician's Assistant of signs/symptoms of infection(new or change in type/amount/color of drainage, bleeding, foul odor) .R1's October 2025 Physicians Orders Sheet (POS) documented orders for a daily skin check using the CROPS method (Clear Red Open Pressure Skin Tear), daily foot check, contact Isolation for ESBL (Extended-Spectrum Beta-Lactamase) in the urine, and (trade name) indwelling catheter, (check) output two times a day. This same POS documented treatment orders as follows:Non pressure chronic ulcer of the right right heel: Cleanse with normal saline, apply Medihoney, apply bordered gauze, (change) every Tuesday, Thursday, Saturday, and as needed, order date 9/24/25.Pressure ulcer to Sacrum: Cleanse with wound cleanser, apply collagen hydrogel, collagen particles, silver sulfadene, and calcium alginate to base of the wound, change every Tuesday, Thursday, and Saturday and as needed, order date 9/24/25.R1's October 2025 Treatment Administration Record (TAR) documented the above wound treatment orders, with a blank space for day shift 10/4/25, indicating the treatments to the wounds of the sacrum and right heel had not been done. R1's Wound Assessment Reports, authored by V4 (Wound Care Nurse Practitioner) documented the following:9/30/25: Stage 4 pressure area, sacrum: Facility acquired: No. Wound status: Improving with delayed wound closure. Length: 9.00 cm (centimeters), Width: 9.00 cm long by width: 81.00 cm, 2 Depth: 6. 00 cm. 70% granulation (tissue), 30% slough. Undermining: from 6 o'clock to 9 o'clock, 6.0 cm. Heavy seropurulent drainage. Odor post cleansing: Malodorous. Arterial ulcer right heel: Acquired in facility: Yes. Wound status: Improving with delayed wound closure. Moderate amount of seropurulent drainage. Odor post cleansing: None. % Granulation: 50% granulation % Slough: 30% slough % Eschar: 20% eschar.10/7/23: Stage 4 pressure area, sacrum: Facility acquired: No. Wound status: Worsening. Length: 9.00 cm Width: 12. 00 cm long by width: 108.00 cm. 2 Depth: 6.00 cm.0% Granulation, 100% slough. Undermining: from 6 o'clock to 9 o'clock, 6.0 cm. Heavy amount seropurulent drainage. Odor post cleansing: Malodorous. Arterial ulcer right heel. Acquired in facility: Yes. Wound status: Improving with delayed closure. Moderate amount of seropurulent drainage. Odor post cleansing: None. % Granulation: 50% granulation % Slough: 30% slough % Eschar: 20% eschar.R1's Nursing Progress note dated 10/7/25 at 10:42am, authored by V3 (Registered Nurse/RN) documented: Wound rounds completed with (V4). Recommendations received to send (R1) to hospital due to worsening sacral ulcer with possible infection and decreased urine output over the last 24 hours. (V4) contacted family members who were thankful for the update and agreed with the recommendations. MD (Medical Doctor) aware.R1's Provider Skin and Wound Note dated 10/7/25 at 1:18pm, authored by V4 documented, Evaluation for follow-up of wound sacrum stage 4 pressure ulcer, current/prior treatments include (trade name sodium hypochlorite solution) collagen, hydrogel, silver sulfadene cream, and calcium alginate. Right heel arterial ulcer, treatment stalled and changed to Santyl. After assessment of wound today, consult was conducted with staff, (V3), and (review of history and physical) and it was decided that patient would be sent to the hospital due to deteriorating wound over the last 4 days. Wound bed to sacrum is necrotic and malodorous with heavy amounts of purulent drainage. According to staff, resident has also felt warm to touch and had very little urine output since (10/5/25) Sunday per her (indwelling) catheter. Urine present in (catheter) bag was dark and had sediment present. Resident was not eating well and looked more tired than usual. She reports she feels terrible at this time