STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056929	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODIN HEALTH AND REHAB CENTER	300 GREEN STREET , ODIN, Illinois, 62870

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2556955/2575048	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)1 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active	S9999		

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

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S9999	Continued from page 1 participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to provide narcotic pain medication per physician orders for 2 of 3 (R1 and R3) residents reviewed for pain management in a sample of 3. This failure resulted in R1 and R3 experiencing unrelieved pain and having to be sent to the local hospital for treatment of pain. This past noncompliance occurred from 06/08/25 to 7/31/25. The findings include: 1. R1's Admission Record dated 08/06/25, documents an admission date of 07/11/25 with diagnoses in part of displaced comminuted fracture of shaft of humerus to right arm, multiple fractures ribs right side, unspecified fracture of unspecified lumbar vertebra, chronic migraine, and other chronic pain. R1's MDS (Minimum Data Set) dated 07/17/25, documents in Section C a BIMS (Brief Interview for Mental Status) score of 15 which indicates R1 is cognitively intact. R1's Care Plan with a date initiated of 07/11/25 has a focus area of "R1 (Resident) has potential for pain from trauma/injuries received prior to admission." Interventions listed are administer medication per physician order(s) and monitor for side effects and effectiveness. Notify the physician /NP (Nurse Practitioner)/ PA (Physician Assistant) if current pain	S9999		

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S9999	Continued from page 2 medication is ineffective or if the resident is experiencing side effects, determine what the resident's optimal pain level is for the day to day function and quality of life, and encourage the resident to request pain medication before the pain becomes too intense or prior to activities that the resident knows there is potential for increased pain (e.g. therapy). R1's Order Summary report with a print date of 08/06/25 documents an order for oxycodone HCL (hydrochloride) oral tablet 10mg (Milligrams) give 1 tablet by mouth every 4 hours as needed for pain with an order date of 07/12/25 and no end date. R1's July MAR (Medication Administration Record) documented on 7/27/25, R1 received Oxycodone 10mg 1 tablet at 10:17PM with a pain level of 6. No other documentation for oxycodone 10mg on 07/27/25. R1's progress note dated 07/27/25 at 1:03PM documents in part "Resident c/o (complained of) extreme swelling and increased pain to R (right) arm. Offered p/t (patient) prn (as needed) Tylenol and Excedrin. p/t refused Tylenol yet accepted Excedrin. Called Pharmacy to gain access code to prn narcotics in pixus (Emergency medication storage) how pixus didn't have prn narcotic was told by pharmacy that prn narcotic would be in tonight's delivery. P/T demanded to be sent to er (Emergency Room). Called (Name of Primary Physician), orders obtained to be sent to (Name of Local Hospital) ER. Gave report to (Name of Local Hospital) ER and (Name of Local Ambulance) (Didn't call 911). Called (R1's) emergency contact to inform… P/t pleased with nurse seeking emergency T/x (treatment)." R1's progress note dated 7/27/25 at 4:12 PM documents, received report from local hospital. R1 was given a lidocaine patch to the right arm, 2 Tylenol, and Oxycodone 10 mg. Caller stated R1 was very happy now. The nurse asked about the swelling to the right arm and shoulder and was told there was no imaging done and that the swelling was part of healing. R1's local hospital records from 07/27/25 documents todays visit diagnoses as other closed displaced fracture of proximal end of right humerus with routine healing subsequent encounter, closed fracture of lumbar vertebra with routine healing unspecified fracture morphology, and closed fracture of multiple ribs of right side with routine healing. On 08/04/25 at 1:57PM, R1 stated that they have ran out of his prn pain medication oxycodone 2 times. R1 said	S9999		

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S9999	Continued from page 3 the first time was when he was first admitted to the facility, and it took a day for them to get the medication in. R1 said that he was in pain then but was able to tolerate it some then. He said that they ran out of it again on 07/27/25. R1 said that he was hurting so bad that day he couldn't tolerate it and he had them send him out to local hospital emergency room to see if they could give him something for the pain since they were out of his oxycodone at the facility. R1 said that the emergency room did give him an oxycodone and put a pain patch on him. R1 said even after the hospital gave him the oxycodone and the pain patch that the pain was still there and didn't help until later. 2. R3's Admission Record dated 08/06/25, documents an admission date of 03/25/25 with diagnoses in part of systemic lupus and chronic pain syndrome. R3's MDS dated 06/26/25, document in Section C a BIMS score of 15 which indicates R3 is cognitively intact. R3's Care Plan with a revision date of 05/23/24 documents a focus area of, " R3 has chronic pain r/t (related to) lupus, CKD (Chronic Kidney Disease), hernia, chronic pain syndrome, sciatica, osteoarthrosis, neuropathy, IBS (Irritable Bowel Syndrome), Gerd (Gastrointestinal reflux disease), depression" Intervention include in part anticipate the resident's need for pain relief and respond immediately to any complaint of pain and monitor/record/report to nurse resident complaints of pain or request for pain treatment. Another focus area "Pain/Opioid Therapy: (Moderate) pain experience(s) related to: (Lupus, chronic pain, sciatica). Interventions for this focus area include administer pain medication as indicated/prescribed. R3's Order Summary with a print date of 08/06/25 documents an order for Oxycodone-Acetaminophen tablet 5-325mg give 1 tablet by mouth every 4 hours as needed for pain do not exceed 3GM (Grams) daily. R3's June MAR documented no oxycodone-acetaminophen 5-325mg was administered on 06/08/25 or 06/0925. On 06/10/25 at 10:18PM oxycodone-acetaminophen 5-325mg was administered with a pain level of 8. R3's Progress note dated 06/08/25 at 1:53PM documents "This resident out of oxycodone. Called the facilities on call to ask how they would like for me to handle the situation because the resident is in pain, and I have no access to the pixis. He said I need to call them after hours for the pharmacy and have them do an	S9999		

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S9999	Continued from page 4 emergency drop off. The pharmacy said they can't do a drop off because his script has expired, and we would have to get hold of the Dr. (Doctor). DON (Director of Nursing) was notified, and resident was informed of what was going on. Dr was called and voicemail was left to get a new script wrote for oxycodone. Resident did agree to take some tyl (Tylenol) in the meantime." R3's Progress note on 06/08/25 at 3:03PM documents, "Dr called back and would like resident sent to (Name of Local Hospital)…" R3's Progress Note on 06/08/25 at 8:40PM documents, "Resident returned to facility per stretcher by (Name of Local Ambulance) no new orders at this time." R3's local hospital record for 06/08/25 documents todays visit diagnoses were generalized body aches and chronic pain due to trauma. R3's hospital record documents R3 arrived from the nursing home via stretcher with complaints of needing his oxycodone refilled. R3 upset nursing home staff did not call his primary physician in time to get a refill. R3 complained of generalized pain of 5/10 at the time. R3 stated he was afraid to go into withdrawals. A dose of oxycodone-acetaminophen 5-325 mg was given along with a does of ondansetron tablet 4 mg. R3's Progress note on 06/10/25 at 6:23AM documents, "R1 was complaining about his oxycodone prn pill. I called pharmacy at 1230 checking on possible time of delivery. I then gave R1 a prn acetaminophen for pain. R1 later called 911 and was transported to hospital via ambulance. He later returned with no complaints or further s/s (signs or symptoms) of illness or injury." R3's Progress note on 06/10/25 at 11:05AM documents, "Pharmacy called today to inform the facility that they need a hard script in order to fill R1's pain medication. I informed them that the script was sent over the weekend and that last night, R1 called the ambulance and sent himself out to ER r/t pain. The pharmacy lady stated that she could get anyone access to the pixus if needed including agency nurses. I asked her what good that does when we request the code, and no one provides a code in a timely fashion. She then checked her records for the script and found it. She told me that R1's pain medication would be on the first run." R3's local hospital record for 06/10/25 documents today's visit diagnosis encounter for medication refill.	S9999		

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S9999	Continued from page 5 On 08/04/24 at 10:58AM, R3 stated that he did have a problem a couple of months ago with the facility running out of his pain medications. R3 said that he went to the hospital emergency room twice in 2 days because he was in such terrible pain, and they didn't have none of his pain medication at the facility. R3 said that on 06/08/25 and on 06/10/25 that the local emergency room administered his as needed oxycodone for pain and then sent him back. R3 stated when he ran out of oxycodone that they did give him some Tylenol to see if it would help and he couldn't take the pain anymore, so he requested to go to the hospital. On 08/04/25 at 11:30AM, V8 (Licensed Practical Nurse/LPN) stated that they did have a problem with getting controlled medication in and that a couple of residents did get sent out to the local hospital emergency room for pain management treatment. V8 couldn't remember what all residents went out to the hospital because they ran out of pain medication and needed pain management. V8 said they did receive training on how to order controlled substance such as pain medication and it has been better, they haven't been running out of pain medication now. On 08/04/25 at 12:00PM, V5 (Registered Nurse/RN) stated that they were having a problem with not getting controlled medications. V5 said they did have to send several residents out to the emergency room for pain management because the facility ran out of their pain medication. V5 said that R1 and R3 were a couple of those residents that they ran out of their controlled substance pain medication, and they had to send them to the emergency for treatment of the pain. V5 said that they were recently trained on how to reorder pain medications and controlled medications. V5 said since they received training that it has improved, and they haven't been running out of resident controlled pain medications. V5 said that when a resident is getting close to running out of their controlled medications that they send over a note to the doctor and then he will send a script over to the pharmacy and then they will call and follow up to see if the pharmacy got the script and then they will send it. V5 said that they also must click on the EHR (Electronic Health Care) and click that you have received the controlled pain medication. On 08/04/25 at 2:44PM, V1 (Administrator) stated that she doesn't know why R1 ran out of his pain medication on 07/27/25 and she doesn't know why R3 ran out of his pain medication as well in June. V1 said they did do an in-service recently with pharmacy to make sure the nurses know how to order controlled substances	S9999		

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S9999	Continued from page 6 correctly and that she thinks this has been helping with making sure all residents who take controlled substances have the medications they need. On 08/06/25 at 8:38AM, V6 (RN) stated that she was working on 07/27/25 when R1 was sent out to the local emergency room. V6 said that R1 was starting to get low on his pain medication oxycodone and he was going to be out of pain medication on 07/27/25. V6 said that they did give R1 a different type of as needed pain medication, but that R1 said he was still in pain. V6 said that R1 was wanting to be sent to the hospital because of his pain. V6 said that they did send R1 to the hospital emergency room. V6 said while R1 was at the hospital they gave him oxycodone, Tylenol and put a lidocaine patch on him. V6 said that when R1 returned to the facility that he was cussing and said that the hospital emergency room didn't help. V6 said that she had sent a reorder for R1's oxycodone over to the doctors' office on 07/25/25 and they were supposed to send over a script for the medication. V6 said that she tried to get the oxycodone out of the emergency medication storage at the facility, but they didn't have oxycodone in the emergency medication storage, V6 said the pharmacy told her that R1's oxycodone would be at the facility on 07/27/25, but the medication never showed up. V6 said she called the pharmacy on 07/27/25 and they said that they didn't have a script for the oxycodone, but after they checked they found the script for the oxycodone. V6 said the pharmacy didn't even check to see if they had the script for oxycodone for R1 until she called. V6 said that it still took a day for them to get R1's oxycodone after they found the script. V6 also stated that she knows that R3 was sent out to the hospital in last month because he ran out of his oxycodone, and he went back and forth to the hospital several times. V6 said that she thinks that they have a better understanding now on how to order the controlled substances. V6 said that they did have recent in-services and reeducation on how to order controlled substances. V6 said that when you need a controlled substance such as oxycodone that you must get a new script and have the doctor send it to the pharmacy. V6 said that you need to order the controlled substance about a week before you run out. V6 said that some of the other nurses thought that the residents had refills left and would just send over a reorder without getting a new script and then the medication wouldn't come in and the resident would be out of the medication. V6 said that since V3 (DON) has done training that getting the controlled substances such as the pain medication has improved, and they have the residents pain medications now.	S9999		

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S9999	Continued from page 7 On 08/06/25 at 10:28AM, V7 (LPN) stated that they did have a problem with getting controlled substance such as pain medications. V7 said that he was working when R3 called 911 himself because he was out of his pain medication oxycodone for a day and half. V7 said that R3 called 911 because he was in pain and didn't have his oxycodone. V7 said the reason that they kept running out of the pain medication was because of a pharmacy thing. V7 said that since they were in-serviced and reeducated that receiving the residents controlled substance pain medications has gotten better. V7 said that some of the problem was that they would only have a script for 6 pills and the resident would go through those quickly and then they would have to get a new script and then wait for the medication to come in again. On 08/06/25 at 11:00AM, V3 (Director of Nursing/DON) stated that she is aware they had a problem with getting controlled substance such as pain medications for the residents. V3 said that she thinks this was a combination of nursing and pharmacy. V3 said that she did a recent in-service and reeducation with nursing and that pharmacy service also came out and talked to nursing staff about how to reorder controlled substance. V3 said that she feels it has gotten better since the in-service/reeducation which was done on 07/28/25. V3 said that she does a daily audit on medication that aren't administered and not available during morning meeting. V3 said that she also does a controlled substance audit usually on Wednesday to check to see if residents are close to needing a refill if so then they will contact the doctor and get a new script and send it to the pharmacy so they can get the medication in before the weekend. V3 said that she will have nursing call and follow up with the pharmacy to make sure they got the new script. V3 said that the admission team is also working with the hospitals to make sure the hospitals send the script for controlled substance with the resident when they get to the hospital so they can order the medication right away. On 08/06/25 at 12:20PM, V4 (Medical Doctor) stated that he knows that R1 and R3 were sent out to the local emergency room because they were out of their controlled substance pain medication and was sent to the local emergency room for pain management. V4 said that he doesn't know why R1 and R3 ran out of their prescribed pain medication. V4 said that when they would call him, he would send over a script to the pharmacy. V4 said that he thought the reason the facility kept running out of the controlled substance pain medication was because of a pharmacy thing. V4 said that when the resident ran out of the controlled	S9999		

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S9999	Continued from page 8 substance pain medication the facility should have been able to get the medication out of the emergency medication storage. V4 said that the facility didn't have the medication in their emergency medication storage, and it was taking almost a day or two for the facility to get the medication from the pharmacy. V4 said they would have to end up sending the resident out to the hospital to get treated for pain and that costs a lot of money to send a resident to the local emergency room for pain management when they could have been treated at the facility. V4 said that he does know that the facility is currently working on fixing this problem, so no resident runs out of their controlled substance pain medication or any medications. V4 said that he knows that they are also working with the hospital to make sure they send scripts with the resident when they return to the facility so they can order the medications right away and have the script so they can send it especially for any controlled substances. The facility policy titled "Administering Pain Medications" with a revision date of October 2010 documented under general guidelines "1. The pain management program is based on a facility-wide commitment to resident comfort. 2. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Procedure step 6 documents "Administer pain medications as ordered." Prior to the survey date, the facility took the following actions to correct the non-compliance: 1. A Quality Assurance and Performance Improvement meeting was held on 07/31/25. In attendance - V1, V3, V4, V9 (Certified Nursing Supervisor), V11 (Activities Director), V12 (Social Service Director), V13 (Housekeeping/Laundry Supervisor), V14 (Dietary Manager), and V15 (Director of Therapy). 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents experiencing pain have the potential to be affected. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur: On 07/28/25 the facility staff were in-serviced by V3 and pharmacy on pharmacy processes including re-ordering of medications and controlled substance prescription processes. On 07/28/25 licensed staff were in-serviced on pain management.	S9999		

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S9999	Continued from page 9 4. Plan to monitor performance to ensure solutions are sustained: V3 or designee will audit medications not available daily during morning clinical meeting weekly x 8 weeks to ensure all medications are available. For any medications not available, facility staff will contact pharmacy to get resolution. Any discrepancies will be discussed at QA (Quality Assurance) committee meeting with recommendations made accordingly. (B)	S9999		