

Illinois State Department of Health

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 11/14/2025	
NAME OF PROVIDER OR SUPPLIER ODIN HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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		S0000			11/21/2025	
	Complaint Investigation 2559872/268759						
S9999	Final Observations		S9999			11/21/2025	
	Statement of Licensure Violations:						
	300.610a)						
	300.1010h)						
	300.1210b)						
	300.1210d)2)3)5)						
	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 300.1010 Medical Care Policies						
	h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.						
	Section 300.1210 General Requirements for Nursing and Personal Care						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: 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 and 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 hospitalized for sepsis and subsequent death. 1. R1's Face Sheet documented an Admission Date of 3/3/22 and listed Diagnoses including Asthma, Peripheral Vascular Disease, Hypothyroidism, Bipolar		S9999				

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S9999	Continued from page 2 Disorder, Hypertension, and Diabetes Type 2. R1's Minimum Data Set dated 10/2/25 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.			S9999			

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S9999	Continued from page 3 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: "Wound	S9999					

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S9999	Continued from page 4 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. Family was contacted and agreed that (R1) would be sent to (local hospital) for further work up, diagnostic testing, and IV (Intravenous) antibiotic therapy." R1's ED (Emergency department) Provider Note dated 10/7/25 at 1:07pm documents "Chief Complaint: Skin Ulcer, Failure to Thrive, Oliguria. The patient is a 71-year-old female that presents the emergency department for the evaluation of progressive weakness, failure to thrive, not wanting to eat or drink, and decreased urine output. The patient resides at (the facility). This has been going on for several days and getting progressively worse. Patient has used a [sic] oriented to self but not very communicative. The staff is concerned that the patient has a sacral ulcer which has been present for some time now but getting progressively worse. The patient is not a very good historian. She denies any pain. She is pretty somnolent and appears fatigued. She does help us assess enroll [sic] her." The Physical Exam documents: Constitutional: Negative for fever. Appearance: She is ill-appearing and toxic-appearing. Comments: The patient is pale. Oriented to self but not very interactive, according to the NH (Nursing Home) this is her baseline. Under Musculoskeletal documents: Large (Sacral) Decubitus to the bone. Foul odor. No active drainage. Pictures in chart. The patient has bilateral heel ulcers. An ED Provider Note dated 10/8/25 at 9:37		S9999				

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S9999	Continued from page 5 AM documents "The patient remained fairly somnolent her whole stay here. Her vitals remained normal but she had minimal interaction. She would deny any pain when I asked her. The patient is to be transferred to (local critical access hospital) but we are still waiting for a bed at this time." R1's ED Provider Note dated 10/8/25 at 5:53pm documents "The patient was moaning in the room The nurse went in to talk to her and the patient denied any pain. She then went apneic and bradycardic. This is shortly before 7 am today. The patient was immediately started to bag and we called family to see if they wanted her to be in fact a full code which they confirmed. At that point the patient was intubated. She became more bradycardic and we did not feel strong pulses, epi (epinephrine) was given and CPR (Cardio Pulmonary Resuscitation) was initiated. The patient was successfully intubated and not very responsive. Levophed was started, the patient was given 3 more doses of epi and her heart rate was just erratic she would be bradycardic PA 1 (clinical reference not found) rhythm looked like the [sic] tach (tachycardia) and she was shocked. The patient just was not responding to interventions. We have has been waiting for family to come but the patient was not doing well not responding to all aggressive measures and the resuscitative effort was stopped. The patient stopped making any attempt at spontaneous respirations. I cannot palpate any pulses or obtain a blood pressure. She was on full dose of Levophed, had head [sic] rounds of epi, CPR and at that time I decided it was time to stop these resuscitative efforts. I could never recovered [sic] the patient. This started approximately 7:00 a.m. this morning and we pronounced the patient is (dead at) 7:49 (am). Post procedure diagnoses: 1. Dehydration. 2. Hyperglycemia. 3. Failure to Thrive in Adult. 4. Skin ulcer of sacrum with necrosis of bone. 5. Urinary Tract Infection without Hematuria, site unspecified. 6. Sepsis, due to unspecified organism, unspecified whether acute organ disfunction present." R1's Culture Wound +Gram Stain Report for the sacrum from the hospital records dated 10/7/25 from the hospital records documented, "Result: Positive: Heavy gram-positive cocci. Positive: Heavy gram-negative bacilli." R1's Blood Culture results from the hospital records collected on 10/7/25 documents culture results on 10/9/25 document growth of Staphylococcus hominis and Gram positive cocci in clusters. R1's Death Certificate documents a date of death of 10/8/25 with Cause of Death: A. Sepsis.			S9999			

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S9999	Continued from page 6 On 10/30/25 at 8:55am, V9, R1's Power of Attorney, stated R1 had resided at the facility about 4 years. V9 stated R1 had been being treated by V4. V9 stated on the morning of 10/7/25, V4 called her and said that "(R1) was very sick, not eating or drinking, no urine output, and needed to be sent to the hospital." V4 stated R1 died in the hospital less than 24 hours from being admitted. V4 stated nobody from the facility called in the days prior to inform her that R1's condition had declined. V4 stated she got R1's Death Certificate which lists the cause of death as Sepsis. V4 stated she believes R1 was septic from her wounds and that, "Poor care had to have caused the sepsis, which caused her death." On 11/4/25 at 11:05am, V4 stated she started coming to the facility on 7/8/25. V4 stated she performs quarterly skin assessments on all residents, and it is staff's responsibility to notify her of any new skin issues or wound deterioration. V4 stated she assumed care of R1 on 7/8/25, and prior to that other wound care providers employed by V4's company were taking care of R1. V4 stated R1 had a stage 4 pressure ulcer to the sacrum and an arterial wound to the right heel. V4 stated the arterial wound was improving and the sacral wound was also responding well to treatment and was improving. V4 stated R1 had chronic conditions which are barriers to healing such as being in bed most of the time, Diabetes, incontinence of stool, and Peripheral Vascular Disease. V4 stated she last evaluated R1 on 10/7/25. V4 stated at the door of R1's room she was met with a strong necrotic smell, which was not usual for R1. V4 stated as she was entering, an unknown CNA (Certified Nursing Assistant) stated that R1 had had very little urine output, had been warm to the touch, and had little intake of food or fluids since 10/5/25. V4 stated the urine in R1's catheter bag was scant, less than 100cc, very dark, and contained sediment. V4 stated R1 was alert but confused, her baseline, but told V4 she, "Felt like (expletive)." V4 stated examination of the sacral wound showed it was obviously worse, with heavy, purulent drainage and a very strong necrotic odor, and the heel wound was about the same as it had been the previous week. V4 stated she told staff the resident needed to go to ER due to signs of wound infection, and arrangements were made. V4 stated she called (V9) to say R1 was going to the hospital due to a decline in her health, and V9 stated nobody from the facility had called V9 to report R1 had declined. V4 stated the facility had not notified R1's Physician about her decline and the signs of infection. V4 stated, "The sacral wound did not get worse overnight. The wound most likely deteriorated because her body was shutting down. (R1) should have been sent			S9999			

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S9999	Continued from page 7 to the hospital sooner, when she had decreased intake and output." On 11/4/25 at 12:58pm, V3, Registered Nurse/Wound Care Coordinator, stated he started in the position on 9/16/25. V3 stated R1's heel and sacral wounds were," Stable," until he and V4 rounded on 10/7/25 and found the sacral wound had deteriorated. V3 stated he works Monday through Friday, and R1 was sent to ER Tuesday 10/7/25. V3 stated he worked Monday 10/6/25 but doesn't recall any staff saying anything about R1 declining over the weekend. V3 stated on that date he did a skin check on R1 and there were no new skin issues noted, including the left heel. V3 stated he could not remember when the dressings on the wounds were dated when he saw them on 10/6/25 or 10/7/25. When asked if he was aware the 10/4/25 wound care treatments had not been done, V3 stated he was not aware, and if it had been done it would be documented on the TAR. V3 confirmed that prior to going in to see R1 with V4 on 10/7/25, V8, CNA, stated R1 "had declined, I can't recall specific details, but I think it had to do with poor intake of food and fluids." V3 stated he recalls V4 removing the sacral dressing but does not remember the date or who signed it. V3 stated when they looked at the sacrum, the wound looked worse and had purulent drainage. V3 stated he thinks at that point he checked R1's vital signs but could not find them in the chart. When asked if R1 had a fever, V3 stated he did not recall her vitals being out of normal range. V3 stated R1 was then sent to the ER upon the orders of V4. On 11/4/25 at 210pm, V8, CNA, stated meal intakes are not to be left blank on the documentation, and that if a resident refuses a meal, it is to be charted. V8 stated 10/7/25 was the first day she had worked with R1 in a while. V8 stated in report she was told R1 had poor food and fluid intake and had very little urine output. V8 stated R1 looked tired, felt clammy and sweaty, and had a very small amount of brownish urine in her catheter bag. V8 stated she does not recall looking at the dressing on R1's right heel, but the dressing on the sacral wound was falling off, soaked with drainage, and she does not remember what it was dated, "But it did have (V3) initials on it." V8 stated she did not get vitals on R1, V8 stated at the facility it is the nurse's responsibility to do vitals. V8 stated R1 refused breakfast and almost all fluids that morning. V8 stated she informed the charge nurse, V16 Licensed Practical Nurse, of R1's status and the condition of the dressing, but by that time, V3 and V4 were going in to see her. On 11/4/25 at 320pm, V11, RN, confirmed she worked 7am		S9999				

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S9999	Continued from page 8 to 7pm on 10/4/25. V11 stated it was the only shift she worked alone at the facility as she was prn (as needed/ on call) staff. V11 stated she did not really remember anything about any of the residents. When asked about there being no documentation that R1's wound treatments were done that day, she stated, "If I didn't document them, I'd say they weren't done." On 11/5/25at 10:45am, V16 (Licensed Practical Nurse/ LPN) stated she worked 7am to 7pm on both 10/6/245 and 10/7/25. V16 stated on weekends, the floor nurses are responsible for dressing changes, with V3 being responsible through the week. V16 stated on one of those days, an unknown CNA, possibly on night shift, told her the dressing to the sacrum had come off during incontinence care. V16 stated she noted a large amount of yellow slough on the wound which had not been present when she had previously changed the dressing, date unknown. V16 stated additionally, the wound had a foul odor and yellow drainage, and the wound bed was darker. V16 stated she did not recall looking at R1's heel wound. V16 stated she didn't specifically recall R1's urine output but, "It was probably inadequate but not unexpectedly so." V16 stated she didn't remember specifically about R1's fluid intake but nobody had reported her refusing food or fluids. V16 stated she did not remember anything about charting on R1, including documenting a dressing change. V16 stated she could not remember hearing anything specific about R1 in report. V16 stated she did recall on Monday, 10/6/25, being aware the sacral wound had deteriorated, but did not feel the need to notify the Physician as she knew V4 was to evaluate R1 the next day. V11 stated she recalled that on the morning of 10/7/25, R1's urine output had decreased, and V4 sent her to the ER. On 11/5/25 at 11:05am, V13, LPN, stated she worked with R1 on the 7am to 7pm shift on both 10/3/25 and 10/5/25. V13 stated on 10/3/25, she recalled R1's fluid intake and urine output were adequate. V13 stated she recalled that R1 had seemed lethargic and was not wanting to eat on 10/5/25 but does not recall what her fluid intake or urine output was like. V13 stated on 10/5/25 R1, "was not acting like herself." V13 stated she did not recall checking her vital signs. V13 stated most residents' vital signs are checked once a week on Friday and in between as needed. V13 stated she did not change the sacral dressing as that is V3's responsibility Monday through Friday. V13 stated she does not recall any odor coming from the wound, but R1's urine did smell strong. V13 stated she did recall telling the oncoming night shift nurse on 10/3/25, V14, Registered Nurse, that R1 had been refusing to eat. V13 stated she did not feel any need to contact the physician about R1.		S9999				

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S9999	Continued from page 9 On 11/5/25 at 12pm V15, RN, stated she worked with R1 on 10/5/25 from 7pm to 7am. V15 stated she does not recall hearing anything concerning about R1 in report. V15 stated V3 does the wound care treatments through the week and the floor nurses do them only on the weekends unless needed. V15 stated she did not recall changing R1's sacral dressing or looking at the dressing and therefore would not have noticed odor to the wound. V15 stated at the end of the shift an unknown CNA told V15 that R1 hadn't had much urine output. V15 stated she checked R1's catheter and it was draining ok, and the urine was light yellow. V15 stated she does not recall how much output or fluid intake R1 had during that shift. V15 stated she does not recall if vital signs were taken on R1, nor does she recall CNA's reporting the resident felt warm. V15 stated nothing in R1's clinical presentation necessitated calling her Physician. On 11/5/25 at 105pm, V12, Physician/Medical Director, stated R1 had multiple comorbidities including Diabetes, Dementia, Hypothyroidism, Failure to Thrive, and Sleep Apnea. V12 stated several months ago R1 had been treated by an infectious disease specialist due to a history of osteomyelitis in the sacral wound and had been on and off antibiotics several times, as due to her overall condition and comorbidities she had difficulty fighting infection. V12 stated R1 had also recently had ESBL in the urine. V12 stated he was aware R1 had wounds which were being treated by V4. V12 stated in having reviewed R1's care, he noted the facility did not contact him in the days leading up to R1's death, but stated they should have, "Called him immediately for any change in condition, especially not eating or drinking or low urine output." V12 stated he would have given orders for R1 to be sent out immediately. V12 stated he had reviewed the ER report, which showed R1's vital signs were pretty stable on admission, her labs in his opinion did not reflect kidney failure but did reflect she was dehydrated. V12 stated R1 was stabilized in ER and they were waiting for a bed to transfer her to a critical access hospital when R1 coded. V12 stated R1 could have sustained a Myocardial Infarction or a Pulmonary Embolism. V12 stated he did not fill out the death certificate but was aware it had listed the cause of death as sepsis. When asked if sending R1 out earlier could have prevented her death, V12 stated, "It's hard to say." When asked if the dressing not being changed on 10/4/25 could have caused the sepsis, V12 stated it could have. V12 stated with R1's history of wound infections, staff should have been more alert to changes in the wound signaling infection.		S9999				

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S9999	Continued from page 10 On 11/6/25 at 9am, V18, LPN, stated she worked the 7pm to 7am shift on 10/6/25 and took care of R1. V18 stated she recalled R1 was having dark urine and decreased output but does not specifically remember the amount. V18 stated nursing staff are informed about urine output by the CNA's and the nurses put it in the chart. V18 stated, "I know we were to be keeping an eye on her urine (output)." V18 stated she thought she recalled hearing in report that R1 was on hospice. V18 stated she did not recall any other staff saying anything about poor fluid intake. V18 stated she did not think she changed or looked at R1's wound dressings that night but does recall R1 had some odor to the coccyx wound. V18 stated she thought she recalled somebody mentioning in the facility's nursing staff group chat, date unknown, that the wound had odor and probably needed to have the treatment changed. V18 stated all nursing staff including administrative nursing staff are tagged in this chat. Nobody reported to V18 that R1 was feeling warm, and V18 does not think R1's vitals were checked. V18 stated there was nothing in R1's presentation that she felt she needed to call her Physician about. On 11/6/25 at 10:20am V17, CNA, stated the urine outputs are to be reported to the nurse who will chart it, and the CNA then documents, "N/A (not applicable)" on the output for that shift. V17 stated she worked with R1 from 6pm to 6am on 10/5/25. V17 stated she recalled hearing in report that R1 was not eating much. V17 stated R1 looked, "Tired, sick and lethargic and maybe dehydrated." V17 recalled R1's urine looking 'darkish.' V17 stated when a resident such as R1 has a catheter, the CNA's are to report the output to the nurse who then charts it. V17 stated on the night shift there are fewer opportunities to offer fluids as most residents are asleep. V17 stated she thinks she offered R1 fluids but is not sure. V17 stated she recalled seeing a clean dry dressing to the sacral area. V17 stated she does not recall any areas to the heels. V17 stated the sacral wound, "Had an odor to it, you couldn't smell it at her door, but you could smell it at the bedside." V17 stated she did not specifically recall informing the nurse about the odor. On 11/6/25 at 11:15am, V1, Administrator, stated that V14, the nurse who worked with R1 from 7pm to 7am on 10/3/25 and 10/4/25, is currently off work with a cardiac condition. On 11/7/25 at 9:10am, V5, LPN/Resident Care Coordinator, when asked about the discrepancy in some adequate urine output observations in the charting,		S9999				

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S9999	Continued from page 11 staff were reporting the output was decreased, stated it is possible the charting was incorrect. V5 stated having both CNA and Nursing staff separately chart the output was confusing, so the policy has been changed the CNA's being responsible for it from now on. V5 stated it is also possible that the previous shift did not empty the catheter, making the output on the next shift larger. V5 stated she was not aware there had been a staff group chat about R1's condition, but in any case, it is not an appropriate way to inform staff of a change in resident condition. V5 stated looking back at everything, when R1 refused all 3 meals on 10/5/25, and had a urine output of less than 500cc, staff should have notified V12. V5 acknowledged staff were aware R1's family wanted all needed lifesaving interventions for R1. A Change of Condition Notification Policy dated 10/7/22 documented, "It is the responsibility of the charge nurse to notify the physician and the responsible party of the resident's condition. It is the responsibility of all staff members to notify the charge nurse and/or the Director of Nursing of noted changes in a resident's condition. The resident's physician and responsible party will be notified of any changes that occur in the resident's condition by licensed personnel as warranted. These changes are to include but are not limited to; (In part:) Symptoms of an infectious process; New onset or change in pressure ulcers; Change in level of consciousness. 2. R3's Face Sheet documented an Admission date of 9/29/25 and listed diagnoses including Chronic Obstructive Pulmonary Disease, Arteriosclerotic Heart Disease, Cervical Spinal Fusion, and Hypertension. R3's Minimum Data Set dated 10/3/25 documented that R3 has no deficits in cognition and is dependent on staff for transfers and toileting. The November 2025 Wound Log documented R3 had a deep tissue injury to the left heel with an onset date of 9/9/25. R3's Care Plan dated 10/7/25 documented a problem area, "Impaired skin integrity as evidenced by area left heel," with a corresponding intervention, "Treatments per physicians orders." R3's Physicians Orders documented a 10/22/25 order, "Cleanse Left heel wound with normal saline or wound cleanser, pat dry, apply mix of silver sulfadiazine cream, hydrogel, and collagen powder, secure with dry dressing every day shift."		S9999				

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S9999	Continued from page 12 R3's Treatment Administration Record (TAR) for October 2025 showed no documentation that this treatment was done from 10/22/25 to 10/31/25. R3's November 2025 TAR showed no documentation that this treatment was done on 11/1/25 through 11/3/25. On 10/31/25 at 9:35am, V3 was observed providing wound care as ordered to R3's left heel, which was noted to have a non-open deep tissue injury. On 11/13/25 at 11am, V3 stated he does the wound care treatments Monday through Friday, and floor nurses are responsible for doing them on the weekends. V3 stated he generally does all the treatments and goes back and documents them at the end of the day. V3 stated he must have forgotten to document R3's wound care treatments. When asked if the treatment was being done on weekends, V3 stated he is not sure. A Pressure Ulcer Policy dated 8/31/23 documented," Purpose: To provide guidelines that will assist nursing staff in prevention, identification, and appropriate treatment of pressure ulcers. It is the responsibility of the Charge Nurse/Designee to care for pressure areas, and provide treatments as ordered. It is the responsibility of the Charge Nurse/Designee to measure and document the pressure areas weekly. It is the responsibility of the Charge Nurse/Designee to monitor for healing progress, and ensure appropriate treatments are in use. It is recommended that the DON/Designee make frequent pressure ulcer rounds with the Charge Nurse. It is the responsibility of the CNAs to report any skin conditions to the Charge Nurse immediately upon identification. 5. The physician is to be notified when, A. Pressure ulcer develops, B. When there is a noted lack of improvement after a reasonable amount of time, and C. Upon signs of deterioration. 7. Documentation of the pressure ulcer must occur upon identification and at least once a week and as needed until healed. Assessment is to include C. Treatment and response to treatment, and E. Update physician and residents POA of any regression of wound." (A)		S9999				