STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145495	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Nursing Center	402 South Center Street Durand, IL 61024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35119 Based on interview and record review the facility failed to ensure staff reported resident bruising for 1 of 6 residents (R1) reviewed for abuse in the sample of 6. The findings include: The facility's Resident Abuse Investigation Report Form for incident date 5/12/25 shows R1 found with large bruise area to right arm, wrist, and hand. The investigation findings shows: Bruising was not present throughout the overnight hours and was first noticed on the morning of 5/13/25 at approximately 8:30 AM. Bruising was not reported at this time and was later reported at 4:10 PM to V7 Social Services Director. Corrective Action taken: V6 Certified Nursing Assistant who identified bruise and failed to report was re-educated on the importance of reporting skin abnormalities. On 5/15/25 at 9:57 AM, V6 said she saw the bruising on the top of R1's fore arm in the morning around 8:30 AM when she was helping R1 get dressed. V6 said she did not tell anyone at that time, it was super busy. V6 said later they called her and asked about when she saw it. V6 said she should have reported it right away to the nurse. On 5/15/25 at 11:49 AM, V7 said she is the abuse coordinator and abuse allegations or injuries of unknown origin such as bruises are to be reported immediately. The facility's Abuse, Neglect, and Exploitation Policy dated 2-1-25 shows The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35119 Based on observation, interview, and record review the facility failed to transfer a resident in a safe manner for 1 of 6 residents (R1) reviewed for safety in the sample of 6. The findings include: On 5/15/25 at 10:15 AM, R1 was dressed at sitting up in her wheelchair. R1 had a large dark purple/red bruise approximately 3 inches long by 1.5 inches wide on the top of her right forearm extending around the outer side of the forearm to the underside of R1's forearm. The bruising almost formed a complete circle around R1's forearm. R1 said the other night she had to go to the bathroom and the girl pulled her by her arm to get her out of bed. R1 stated she doesn't have the strength to push herself up and the staff pulled her arm to help get her up. R1 said the girl was in a hurry trying to get her up, but it wasn't intentional. R1 said she didn't remember her name, but it was nighttime and it was dark outside. The facility's Resident Abuse Form dated 5-12-25 shows R1 stated overnight Certified Nursing Assistant grabbed her arm to assist her from sitting to standing. R1 felt as thought this was rough but did not feel it was abusive. R1 feels she was improperly transferred during cares. On 5/15/25 at 9:25 AM, V2 Director of Nursing said she had assisted to investigate R1's bruise and watched the cameras to determine the staff that had entered R1's room. V2 said V5 Registered Nurse and V8 Certified Nursing Assistant (CNA)were the only staff that cared for R1 that evening. V2 said V5 went in around 11:30 AM to pass medications and then did not go into the room until morning for AM medications. V2 said V8 went into R1's multiple times that shift. On 5/15/25 at 10:22 AM, V8 Agency CNA said during her shift on 5/12/25 to 5/13/25, R1 had to go to the bathroom. V8 said it was her first time getting R1 out of the bed, R1 had never gotten out of bed before on night shift. V8 said R1 told her she could stand up on her own with the walker so she assisted R1 to stand and then held the gait belt on R1's waist. V8 said R1 was able to sit up by herself at the bedside. V8 said after returning from the washroom, R1 slept the rest of the evening. On 5/15/25 at 9:42 AM, V4 CNA said she works with R1 often and R1 can stand and pivot with a gait belt for transfers. V4 said R1 does need some assist with bed mobility. V4 said she was told about R1's bruising and when she saw it, from where the bruise is located, her first thought was who put their hand there? V4 said it looks like improper handling to her. V4 said R1 doesn't' flail her arms around so she wouldn't have bumped it on anything. V4 said staff should use a gait belt and hold the gait belt to assist R1 out of bed to stand. On 5/15/25 at 9:57 AM, V6 CNA said she worked with R1 the morning shift on 5/13/25 when she noticed the bruise on R1's forearm. V6 said R1 said staff pulled her around by her arm and that's how she got the bruise. V6 said R1 is a one person assist with a gait belt and if R1 needs help to sit up in bed, you don't grab her by the arms to pull her up to a sitting position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 11:49 AM, V7 Social Service Director said when she spoke to R1 about the bruise, R1 told her the night staff had pulled her up by her arm to get her out of bed. V7 said R1 said she didn't feel like it was abusive or intentional. V7 said their investigation concluded that it was an improper transfer and V8 was re-educated on transfers and an in-service was done. R1's Care Plan dated 3/20/25 shows R1 has diagnoses of weakness, muscle weakness, chronic fatigue, primary generalized osteoarthritis,and chronic pain. This same Care Plan shows R1 transfers with one assist and a gait belt and requires one person to reposition and turn in bed. The facility's undated Gait Belt Policy shows It is the policy of this facility to instruct all staff in the proper use of a gait belt and encourage the use of them with all non-mechanical transfers.