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	06/10/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (R1) with a high elopement risk was supervised. This applies to 1 of 3 residents reviewed for safety and supervision in the sample of 3. The findings include: R1's electronic face sheet printed on 6/10/25 showed R1 was admitted to the facility on [DATE] and has diagnoses including but not limited to dementia with severe agitation, anxiety disorder, and hypertension. R1's admission care plan dated 6/4/25 showed R1 is independent with ambulation and has a (departure alert system) on her right wrist. R1's elopement risk assessment dated [DATE] showed R1 is a severe elopement risk. The facility's initial incident investigation dated 6/6/25 showed, At approximately 8:19am CNA (Certified Nursing Assistant) came over walkie and questioned staff on location of resident. Nurse replied with activation of (departure alert system) procedure for viewing each (departure alert system) resident. Within the search we were unable to locate 1 resident. During (departure alert system) procedure, DON (Director of Nursing) and other designees began searching rooms, bathrooms, closets, and any other place resident could be in nursing home. Then, once (departure alert system) procedure was complete, all staff began searching in nursing home and surrounding outside areas. DON and designated staff went to search all floors of attached apartment building. DON contacted Administrator and during this conversation DON was alerted that resident in question was safe and at her daughter's house. Admissions director confirmed with family that resident was there and safe. Therefore, writer did not involve police. Spoke with family to discuss best options for placement moving forward. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 11:57AM, V2 (DON) stated, When we received the initial referral for (R1), our admissions coordinator went and did the initial assessment. Nothing seemed off and (R1) had not tried to elope at her daughter's home so we assumed as long as we kept an eye on her, and she had the (departure alert system) monitor on we could keep her safe. (Admissions Coordinator) came back from the assessment and said (R1) was a good fit for the facility. She stated (R1) was ambulatory and basically independent in all tasks. We all just believed her and then when she came, she was pleasant, but definitely wasn't happy about being in a facility. Her daughter actually took her home that first night for a home visit because she felt guilty and then brought her back the next morning which I think confused (R1) on what was happening. On 6/6/25, we watched our camera footage and we can see (V7-Caregiver) pulling out of the parking lot at 8:12AM and (R1) getting into her car at 8:13AM. (V7) was interviewed by our staff and she stated that (R1) was outside and she asked if she needed help and (R1) said she was here visiting and her ride hadn't shown up yet so (V7) offered her a ride. (R1) was able to tell (V7) her daughter's address so that's where (V7) took her. I was told that (R1) had been overall calm until that morning when she had her bags packed and was saying things like this was a nice visit but it's time for me to go home now. Had I known about those statements I probably would have put her on a 1:1 or 15-minute checks because she was obviously trying to leave the facility. I was the one who initially put (R1's) (departure alert system) on her. I did not test the alarm when I put it on her because it was brand new, so I assumed it was activated and ready to go. Surveyor was not able to view camera footage and did not receive a return call from V7 for interview. On 6/10/24 at 1:01PM, V4 (R1's Daughter) stated To my knowledge she was fine and secure and safe at the facility on Friday. At around 8:30AM, my neighbor knocked on the door and they said your mom is out here. I was shocked and she didn't know how she got there. (Facility) told me that someone that does not work for them but is a caregiver at the apartments next door, approached her outside and offered her help and gave her a ride to my house. This woman brought her to my house and just left. She didn't make sure she was ok, she just left. (Facility) called me around 9:00AM and asked if my mom was there and I said she was. I didn't call the facility to let them know she was here because that's not my responsibility. Nobody called me personally and let me know they were bringing her home. Apparently, this girl found my husband's social media account and sent him a message saying that she was dropping my mom off at our house. By the time he called me the facility was already calling me. It's the only place I really want her to be. My concern is that this person just took her from the grounds without even asking anyone or checking with the facility. My mom paces a lot on the sidewalk, but she has never left the property at home. My plan is to take her back there now that we have a good plan in place to keep her safe at (facility). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 1:59PM, V5 (Registered Nurse) stated, I checked on (R1) right before I went downstairs and told the aides to watch her because she had her bags packed. It was around 7AM and the alarm did sound for its routine test. It does a test at 7AM and 7PM and when staff silence the alarm they check in and outside the doors to make sure it was just the test and not a resident leaving. I'm not sure who was the one who responded to that 7AM alarm on the morning of the 6th but I remember watching them look outside the door to be sure there wasn't a resident there, specifically (R1) because she was agitated that morning. You don't have to do anything to reset it, you just put the code in, and it shuts the alarm off and it's already in activation status. (V6-Agency CNA) checked on her before breakfast and she was gone. She got on the walkie and asked if anyone had eyes on her. I don't know if she had tried to leave before, she was very pleasantly confused. We do (departure alert system) checks every night shift. There is a box we take around and we wave it around (departure alert system) and it will beep and if it doesn't you replace the (departure alert system). Our new process though is to check them every shift because (R1's) was checked on the 6/5 night shift and was working so I'm not sure why it didn't alarm. On 6/10/25 at 2:19PM, V6 (agency CNA) stated, (R1) was exit seeking that whole morning. She kept coming around us and had a bag and said she wanted to go to her daughter's house. She was up here around 7:30AM and was just sitting in her room when I went downstairs to help feed residents breakfast. There were 3 other aides upstairs still getting residents up for breakfast and there was a housekeeper on the hall, I think. I know there was also some administrative staff here so I felt confident that there were enough people upstairs to keep an eye on her plus she had the (departure alert system) on so that would notify us if she tried to leave. She hadn't set off any of the door alarms at all that morning and she didn't try to get outside, she was just kind of lingering around doors. When I came back up around 8:19AM she was gone so I alerted the nurse. I searched the whole hallway, and we went over to apartment side and up the center hallway. Soon after that, we were notified that she was at her daughter's house and safe. I have no idea why her alarm did not go off because it's on her wrist, so we were able to see that it was still on her that morning. Looking back, we probably should have tried to take her down to breakfast with the first seating so we could keep a better eye on her. The facility's undated policy titled, Wandering, unsafe resident showed, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for wandering .3. Staff will check each (departure alert system) on every resident weekly for proper working condition. If (departure alert system) is found to not be working properly, it will be replaced immediately.