

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Medina Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 7. The findings include: R1's face sheet showed he was admitted to the facility 8/11/25 with diagnoses to include malignant neoplasm of prostate, acute posthemorrhagic anemia, severe protein calorie malnutrition, depression, hypertension, mild cognitive impairment of uncertain or unknown etiology, muscle wasting and atrophy, and dysphagia. R1's 8/21/25 facility assessment showed R1 is severely cognitively impaired and is dependent upon staff for cares. On 9/10/25 at 12:06 PM, V6 CNA (Certified Nursing Assistant) said, It was my first day there. I was working with V5 (CNA) at first and was washing people up and assisting to their wheelchairs. V4 CNA asked for help with a transfer, so I went with her. When we went into [R1's] room, [V4] walked up to the bed and said, 'This is [NAME], he is a f**king asshole who thinks because he is a veteran he can treat people like shit.' [R1] looked right at me and said, 'Help me, they don't treat me well here.' I watched videos for orientation before starting work there and it was clear what was considered abuse. It talked about using foul language in the presence of residents and she was using many cuss words. I notified staff of my concerns the same day when I left there. I talked to [V7 ADON (Assistant Director of Nursing)]. The facility's Resident Abuse Report Form showed an incident reported regarding R1 on 9/4/25 at approximately 6:40 AM. The facility's Abuse Investigation Report showed, On September 4, 2025, at approximately 12:56 PM, [V6 CNA (Certified Nursing Assistant)] reported to ADON (Assistant Director of Nursing) via text. [V6] describes an encounter between [R1] and [V4 CNA], that she felt was abusive towards the resident. [V6] describes [V4] yelling at [R1] and cussing at him while applying cares. The encounter caused [V6] to feel extremely uncomfortable and resulted in her leaving the building before her shift had ended. An investigation was launched shortly after when Social Services was alerted of the circumstances. there is sufficient evidence demonstrating that verbal abuse has occurred. Camera surveillance matches the details expressed from [V6] following the text message conversation she had with V7. All abuse had taken place within the resident's room and in his presence. Due to the extreme findings of this case; [V4] has been terminated of her duties with [the facility] . On 9/10/25 at 1:10 PM, V7 ADON said the investigation was initiated because [V6] CNA was scheduled to train that morning and she just left in the middle of her shift and didn't tell anyone. V7 said around 1:00 PM that day she texted V6 to see if she could find out why she left the facility without telling anyone. V7 said, That is when she told me she wasn't comfortable and didn't like the way the CNA was talking to the resident. We just kind of continued the conversation from there. V7 said they hadn't had any concerns about V4 so they were surprised by this incident. V7 said the facility has a camera right outside of R1's room and R1's door was open, so they could hear what went on. V7 said V6's description turned out to be accurate. The facility's Termination Documentation Form signed 9/5/25 showed V4's employment was terminated due to improper conduct/carelessness, safety violation, and a policy and procedure violation. The same document showed, Founded verbal abuse against a resident witnessed on camera. The facility's policy and procedure with revision date of 5-2025 showed, Abuse, Neglect, and Exploitation Policy; Policy Statement: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implanting written policies and procedures that prohibit and prevent abuse. Verbal Abuse the use of oral, written, or gestured communication or sounds that willfully include disparaging and derogatory terms to residents or their families or within their hearing distance regardless of their age, ability to comprehend, or disability.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an allegation of abuse was reported immediately for 1 of 3 residents (R1) reviewed for abuse in the sample of 7. The findings include:R1's face sheet showed he was admitted to the facility 8/11/25 with diagnoses to include malignant neoplasm of prostate, acute posthemorrhagic anemia, severe protein calorie malnutrition, depression, hypertension, mild cognitive impairment of uncertain or unknown etiology, muscle wasting and atrophy, and dysphagia. R1's 8/21/25 facility assessment showed R1 is severely cognitively impaired and is dependent upon staff for cares. On 9/10/25 at 12:06 PM, V6 CNA (Certified Nursing Assistant) said, It was my first day there. I was working with V5 (CNA) at first and was washing people up and assisting to their wheelchairs. V4 CNA asked for help with a transfer, so I went with her. When we went into [R1's] room, [V4] walked up to the bed and said, 'This is [NAME], he is a f%king asshole who thinks because he is a veteran he can treat people like shit.' [R1] looked right at me and said, 'Help me, they don't treat me well here.' . I watched videos for orientation before starting work there and it was clear what was considered abuse. It talked about using foul language in the presence of residents and she was using many cuss words. I notified staff of my concerns the same day when I left there. I talked to [V7 ADON (Assistant Director of Nursing)].The facility's Resident Abuse Report Form showed an incident reported regarding R1 on 9/4/25 at approximately 6:40 AM. This same document showed the allegation was reported at approximately 2:00 PM. The facility's Abuse Investigation Report showed, On September 4, 2025, at approximately 12:56 PM, [V6 CNA (Certified Nursing Assistant)] reported to ADON (Assistant Director of Nursing) via text . [V6] describes an encounter between [R1] and [V4 CNA], that she felt was abusive towards the resident. [V6] describes [V4] yelling at [R1] and cussing at him while applying cares. The encounter caused [V6] to feel extremely uncomfortable and resulted in her leaving the building before her shift had ended. An investigation was launched shortly after when Social Services was alerted of the circumstances. there is sufficient evidence demonstrating that verbal abuse has occurred. Camera surveillance matches the details expressed from [V6] following the text message conversation she had with V7. All abuse had taken place within the resident's room and in his presence. Due to the extreme findings of this case; [V4] has been terminated of her duties with [the facility] . On 9/10/25 at 1:10 PM, V7 ADON said the investigation was initiated because [V6] the CNA that was training that morning just left the facility in the middle of her shift without telling anyone. V7 said later that day, around 1:00 PM, she texted V6 to see if she would respond and find out why she left. V7 said it was at during that text conversation that V6 reported that she left because she wasn't comfortable with the way another CNA was talking to a resident and we just kind of continued the conversation from there. V7 said V6 should have reported it right away to the floor nurse, social service director, or she could have reported to [V7] or the DON (Director of Nursing). V7 said, it was her very first shift too so she should have known, after going through orientation, that she was supposed to let someone know right away.The facility's Termination Documentation Form signed 9/5/25 showed V4's employment was terminated due to improper conduct/carelessness, safety violation, and a policy and procedure violation. The same document showed, Founded verbal abuse against a resident witnessed on camera.The facility's policy and procedure with revision date of 5-2025 showed, Abuse, Neglect, and Exploitation Policy; Policy Statement: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implanting written policies and procedures that prohibit and prevent abuse. Verbal Abuse the use of oral, written, or gestured communication or sounds that willfully include disparaging and derogatory terms to residents or their families or within their hearing distance regardless of their age, ability to comprehend, or disability. g. Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents, and grievances without fear of retribution and provide [NAME] regarding the concerns expressed. The reporting process is as follows; iii. Report the allegations to the Administrator and Social Services immediately after reporting to nursing. By doing so, the investigation will begin and all other necessary agencies, etc will be notified via the Administrator or Social Services.</p>		