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	05/01/2026

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.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement fall interventions and update a residents care plan for a resident with a history of falls (R1). The facility also failed to investigate a resident's falls, update their care plan, and implement fall interventions (R3) for a resident with a history of falls. This applies to 2 of 3 residents reviewed for falls in the sample of 4. The findings include: 1. R1's admission Record (Face Sheet) showed an admission date of 8/28/25 with diagnoses to include but not limited to neurocognitive (brain) disorder, repeated falls, aphasia (impaired speech), and failure to thrive. R1's 2/25/26 Quarterly Minimum Data Set (MDS) showed Brief Interview for Mental Status could not be completed and he had both short and long-term memory issues. The MDS showed he used a walker and wheelchair; and he had range of motion limitations to both arms. The MDS showed he was dependent upon staff for all forms of transfer (bed, chair, and toilet) and he required substantial/maximal (staff do more than half the effort) assistance for walking 10 and 50 feet. R1's 2/4/26 Social Service note from 3:46 PM showed, Family meeting held with ADON (Assistant Director of Nursing) and [R1's] sister, whom is his POA (Power of Attorney). She expressed concerns of [R1] having a decline in his health and the changes that have come with it. For example, [R1] used to walk to and from his meals and now he is using the wheelchair to go to and from meals. POA would like [R1] to walk whenever he possibly can and use his wheelchair when it is appropriate. However, after such, POA would like for [R1] to be brought back from his room with guidance of CNA's (Certified Nursing Assistant) and helped back into his recliner to relax instead of waiting in his wheelchair in the lounge. The note continued, .Social services and nursing agreed that these plans and goals were obtainable and will help support family and his wishes. R'1s 3/30/26 Fall Documentation from 7:34 PM showed he had an unwitnessed fall in the lounge. The note showed, Found on floor in lounge in front of wheelchair. R1's 4/14/26 Fall Documentation from 5:45 PM showed another fall in the lounge. The note showed the only witness was R4. The note showed R4 stated the fall happened quickly. The fall note showed R1 had been placed in the lounge, after the evening meal, by V11 Transporter. The note showed R1 sustained superficial scratches to his left arm and a bump on his forehead. The note showed R1's POA declined Emergency Department (ED) evaluation. (Note authored by V8 Registered Nurse). On 4/30/26 at 3:22 PM, V8 stated R1's 4/14/26 fall was unwitnessed by staff. V8 stated R1 had been placed in the lounge, following the evening meal, and was not supervised. V8 stated herself, V11, and the other staff she spoke to on 4/14/26 were not aware R1 had instructions that he should not be left in the lounge unattended after meals. V8 stated I immediately called his sister after the fall and his (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressed, there was no basin of water or wash clothes near him. She should have gathered all his supplies before going in. He has fallen so many times so she should be prepared. On 5/1/26 at 10:55 AM, V2 DON stated, regarding R1's fall on 4/18/26, My expectation is if they walk away, they have to lower the bed and put the fall mats in place. The purpose of lowering the bed and the fall mat is to prevent injury or minimize the severity of the injury of the fall. The facility's Fall Prevention and Management policy (Undated) showed, .Falls can also lead to severe complications including hip fractures, traumatic brain injury and premature death. As all falls cannot be prevented, [the facility] strives to minimize potential injury by identifying common fall risk factors and developing individualized care plan interventions that focus on maintaining a person's independence and mobility function to the best of their ability. [The facility] assesses all residents and evaluates fall situations as well as potential fall/injury situations in order to achieve this goal. 2. R3's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include hypertensive heart and chronic kidney disease with heart failure, Type 2 Diabetes, dementia without behavioral disturbance, obstructive sleep apnea, peripheral vascular disease, and arthropathy. R3's facility assessment dated [DATE] showed he has severe cognitive impairment and requires substantial to maximum assist of staff for most cares. R3's medical record showed he experienced 10 falls between 1/10/26 and 4/26/26. R3's 4/26/26 Fall (Initial Documentation) Note showed, Time of fall: 1:40 PM. Witnessed. Son at bedside for the whole incident. Son states patient was moving around the room in wheelchair and started to slide out of his chair. At this time, son was able to assist patient gently on the floor avoiding any head trauma. R3's 4/22/26 Fall (Initial Documentation) Note showed, Time of fall: 6:15 PM. witnessed by another resident. laying on hallway floor. he was in his chair and slid out. skin tear to right elbow. R3's 4/4/26 Fall (Initial Documentation) Note showed, Time of fall: 7:50 PM. Unwitnessed. Resident says he was moving up and down the hallway in his wheelchair. Resident slid from his wheelchair to the floor as staff was walking up and down. R3's 3/22/26 Fall Follow Up Note showed, Nurse was called in room by CNA stating while walking past residents room chair alarm was going off and CNA saw resident slipping from wheelchair onto floor. Resident stated, I don't know, with a big smile on his face. Nurse assessed resident. Patient was on floor in sitting position with back against wheelchair. R3's 2/21/26 Fall (Initial Documentation) Note showed, Time of fall: 12:0 PM. unwitnessed. Resident attempting to use restroom. sitting on buttocks. Injuries: small 1.5 cm skin tear to left upper extremity. R3's 2/12/26 Fall (Initial Documentation) Note showed, Time of fall: 4:20 PM. Unwitnessed. Resident is alert and states that he did not hit his head while falling in his room. On the floor in doorway of his room on his back. Resident was going into his room and chair went out behind him. Two wounds noted on right arm. One at right elbow and another 2-4 inches from elbow. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's 2/12/26 Fall (Initial Documentation) Note showed, Time of fall: 3:30 PM . witnessed. he slid out of his chair. Witnessed, resident was in another resident's room being aggressive. R3's 2/11/26 Fall (Initial Documentation) Note showed, Time of fall: 9:00 AM. unwitnessed. On floor in room laying on his back. R3's 1/23/26 Fall (Initial Documentation) Note showed, Time of fall: 11:35 PM. unwitnessed. he was walking unassisted by staff and fell. His alarm was not sounding. Back up against the room door, leaning on right elbow, legs stretched out in front of him. resident stated he was going to the bathroom. R3's 1/10/26 Fall (Initial Documentation) Note showed, Time of fall: 7:00 PM. unwitnessed. patient unable to provide details due to chronic baseline altered mental status. Patient assumed to have been attempting to use the toilet but there is not any evidence of toilet use, patient declined to use the toilet after fall assessment, and incontinent brief clean and dry. R3's Care Plan initiated 7/17/25 showed, [R3] is at risk for falls related to Dementia, CHF (congestive heart failure), Asthma, Type 2 Diabetes. This care plan shows no interventions added since the care plan was initiated 7/17/25. On 5/1/26 at 12:21 PM, V2 DON (Director of Nursing) said, We have talked about what we do for falls and how we do meetings. [V1] started a fall PIP (performance improvement plan). We talk about different things. We do a monthly meeting, and she has been trying to put new things in place and track more than we used to about falls. In the February meeting, we talked about bed and chair alarms, talked about [R] and his self-transferring, we talked about a new policy for making sure the alarms have new batteries and are tested. In our 3/11/26 meeting we had our Restorative CNA come down and talk about alarms. Different sounds and what you might hear if the battery is dying. We had our April quality assurance meeting, and we went over the falls and [V1] got more detailed in her tracking. For fall prevention we use alarms, different chairs depending on the person, with [R3] we tried multiple different chairs, got to the broda because of the way he sits in the chairs, we can do toileting programs, there are certain people that might need to be kept occupied in activities or hanging out at the nurses station. I come in every morning and look at notes, so that I can see when there is a fall. I will take that information, put it in my notebook, talk about it in morning meeting. We talk about interventions we can try and put in place. For [R1], Hospice is informed of any falls. with him they were very involved because his falls are so habitual. They were involved with trying the different chairs. He has behaviors when we try to sit him up straight in the chair. The care plan updates depend on where it is going to be at in the care plan. If the interventions have to do Restorative Nursing, I would be the one updating the care plan. If it goes on the fall care plan, that would be only me who would add. I think I am the only one who touches the fall care plan. My investigations would be looking at history. For R3, with him having multiple falls, we tried multiple chairs, added alarms, and talked to family and seen if there was something that would help with him. I like to add broda chairs to care plans, but I don't think I put his chair on his care plan. I don't have any formal fall investigations. The facility's undated policy and procedure showed, Fall Prevention and Management. [The facility] seeks to promote an active and healthy lifestyle with respect, dignity and security for reach resident as a whole. Falls are the leading cause of injury-related death for those 6 years of age and older. Falls can also lead to severe complications including hip fractures, traumatic brain injury, and premature death. As all falls cannot be prevented, [the facility] strives to minimize potential injury by identifying (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	common fall risk factors and developing individualized care plan interventions that focus on maintaining a person's independence and mobility function to the best of their ability. [The facility] assesses all residents and evaluates fall situations as well as potential fall/injury situations in order to achieve this goal. Post Fall management: . E. Intervention to prevent a similar recurrence will be initiated by the licensed nurse on duty and will be indicated in the initial fall report to enable follow through and staff will be alerted of recent falls and/or interventions put into place. Fall Investigation. A). Falls are reviewed during the daily department meeting, interventions are discussed, approved or added to, depending on situations. B. Care plan coordinators review the care plan areas of the residents who have fallen in order to assure that interventions are adequately documented and communicated.