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	05/26/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review the facility failed to identify a resident's new, non-pressure wounds. The facility failed to perform weekly wound assessments on a resident's wounds. These failures resulted in R2 being hospitalized for cellulitis (bacterial skin infection) of his left foot after maggots were found in R2's left foot wounds. These failures apply to 1 of 3 residents (R2) reviewed for wounds in the sample of 6.The findings include:R2's admission records dated 1/2/26 showed R2 was admitted to the facility with diagnoses including cellulitis of his bilateral lower legs, peripheral vascular disease, lymphedema, obesity, and congestive heart failure. R2's infection notes, and Treatment Administration Records (TAR) dated 4/15/26-5/13/26 showed R2 received daily dressing changes to his bilateral lower legs due to his diagnosis of cellulitis. The notes showed R2 had redness, swelling, open areas, and drainage to the wounds on his lower legs. These notes showed no wound measurements of the wounds on his lower legs. These notes showed no documentation of any wounds to R2's left foot or toes on his left foot. R2's April 2026 Medication Administration Record (MAR) showed R2 was administered antibiotics, from 4/13/23-4/23/26, for treatment of his lower leg cellulitis. These notes showed R2 was noncompliant, at times, with offloading his lower extremities in an attempt to reduce his lower leg swelling. R2's electronic medical records dated 4/15/26-5/13/26 showed only one weekly wound assessment was completed on R2's bilateral lower leg wounds during this time. R2's wound assessment, completed by V4 Registered Nurse (RN) on 5/1/26, showed R2 had wounds to his posterior and anterior bilateral lower legs. The assessment showed R2 also had wounds to his toes on both of his feet. The assessment does not show any measurements for the wounds on his legs or feet. The assessment does not show where the wounds on his toes were located, or which toes were involved. The note showed, Bilateral lower extremities with excoriated with sloughing skin, red, swollen, left worse than right. 2 small open areas to left anterior lower leg, from knee to toes ruddy, bilateral feet swollen/red.Left anterior foot skin sloughed off, draining serosanguinous drainage. The assessment showed no documentation that a physician or nurse practitioner were notified of R2's wounds. R2's progress notes dated 5/14/26 showed nursing staff found multiple maggots in new wounds noted between R2's toes on his left foot. R2 was transported to a local hospital for an evaluation of his wounds. R2's hospital records dated 5/14/26-5/21/26 showed R2 was admitted to the hospital for the diagnosis and treatment of cellulitis to his left foot. The records showed maggots were found in open wounds between the first and second toes of R2's left foot and between the third and fourth toes of his left foot. R2 was discharged back to the facility on 5/21/26. On 5/26/26 at 10:15 AM, R2 was seated in a wheelchair in his room. A gauze and elastic bandage was noted to R2's left leg; from his left knee down around his toes. R2 stated, My legs and feet are always swollen. I really don't have any problems with the wound care here. They changed my dressings (to his lower legs) every day. They just didn't always look between my toes. R2 stated he had no idea how long he'd had the wounds with maggots between the toes on his left foot but stated he'd had increased pain to his left foot for about a week prior to the facility finding his left foot wounds. R2 stated he could not feel the maggots in the wounds in his foot. R2 stated he'd had a history of refusing to offload his lower legs in the past. On 5/26/26 at 11:00 AM, V3 Assistant Director of Nursing (ADON) stated she had recently taken over as the facility's wound nurse. V3 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	stated the facility did not have a wound physician. V3 stated all resident wounds are treated by a resident's primary care physician and/or nurse practitioner. V3 stated staff are to assess residents' skin daily. Residents with wounds are to have a wound assessment done once a week. V3 stated all wound assessments are to include wound measurements and a description of each wound. V3 stated the bedside nurses are responsible for completing weekly wound assessments on residents. V3 stated any new swelling, redness, and/or wounds are to be assessed by nursing and reported to a physician immediately. V3 stated R2 had a history of chronic wounds to his lower legs due to lymphedema and peripheral vascular disease. V3 stated, prior to 5/14/26, she was aware that R2's feet and toes had been swollen, however R2 never had wounds to his feet that she was aware of. V3 stated the facility had completed only one wound assessment on R2 from 4/15/26-5/13/26. V3 stated, on 5/14/26, she assisted R2's bedside nurse, with changing the wound dressings to R2's lower legs. During the wound dressing change, R2 complained of increased pain to the toes on his left foot. V3 stated, His toes (on his left foot) were very swollen and red. When I spread his first and second toes apart, I saw the wound with maggots in it. We immediately called the doctor. I am not sure how long he had the wound or maggots. On 5/26/26 at 1:15 PM, V4 RN stated she completed the wound assessment on R2 on 5/1/26. V4 stated the toes to R2's left foot appeared red and swollen at that time. V4 stated R2 also had a wound to the top of his first (big) toe on his left foot but stated, I thought he always had that. I didn't think it was new. V4 stated she couldn't recall if she had assessed or looked in between R2's toes during her assessment. V4 stated she did not notify R2's physician or nurse practitioner of R2's wounds on 5/1/26. R2's TAR dated 5/12/26 and 5/13/26 showed V7 RN completed R2's daily wound dressing changes to his lower extremities. On 5/26/26 at 12:25 PM, V7 stated, on 5/12/26 and 5/13/26, R2 did complain of pain to his left foot and toes during his dressing changes. V7 stated, I did look between all his toes (on his left foot) as much as I could, but it was painful when I touched them. I didn't see any maggots. The skin between his toes was mushy and red but his skin always looked like this. V7 stated she did not notify a physician or nurse practitioner of R2's left foot pain. R2's progress note dated 5/10/26 showed R2 was seen and assessed by V5 Nurse Practitioner (NP). On 5/26/26 at 11:40 AM, V5 NP stated when she assessed R2 on 5/10/26, R2's left lower leg and foot were covered with a bandage. V5 stated she did not remove the bandage to assess R2's left leg or foot. V5 stated she was never notified that R2 was having left foot pain and/or that he had wounds to the toes on his left foot prior to 5/14/26. V5 stated, (R2's) toes and feet were usually swollen. He was noncompliant with offloading his feet and would refuse his meds. If (R2) was having increased pain to his foot, staff should have assessed his foot along with looking between his toes for a source. Any new findings should have been reported to me immediately. We had been actively treating the cellulitis to his lower legs, but I wasn't aware of any wounds on his feet. V5 NP stated, on 5/14/26, the facility notified her R2 had new wounds between his toes on his left foot with maggots noted in the wounds. V5 stated she had no idea how long R2 had the wounds between his toes.The facility's Wound Care policy dated April 2026 showed, This policy pertains to wounds where the skin is broken-for example, but not limited to-skin tears, lacerations, pressure injuries. When the nurse is aware of skin wound/breakdown, whether in-house or upon a resident's admission, area is assessed. If acquired in-house, the resident's PCP (primary care physician) is notified for further treatment orders. The nurse that identifies the skin issue will notify the facility wound care nurse. Documentation of open wound must occur upon identification and at least once a week. The physician and/or facility wound care nurse is to be notified if no improvement is noted after a reasonable period of time, and/or upon signs of deterioration.The facility's Prevention and Intervention of Skin Breakdown policy (undated) showed all resident wounds will be assessed and measured at least once a week.