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	06/25/2026

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

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure the Illinois Department of Public Health survey results were accessible to residents. This failure affects all residents residing in the facility. The findings include:The facility's census report dated 6/23/26 showed 47 residents currently residing in the facility. On 6/24/26 at 10:00AM, R4, R7, and R16 attended the resident council meeting. All 3 residents stated that the survey results are in someone's office, but they are unsure of who's office they are in. Surveyor toured the facility following the resident council meeting and was unable to find the survey results nor was there a sign indicating where survey results were available. On 6/25/26 at 7:55 AM, V1 (Administrator) stated, We do have the survey results binder, but it is in my office so it's locked when I am not here. we do not have a sign or anything anywhere telling residents or visitors where it is at. They would have to ask for it and if I'm not here there aren't any floor staff that would be able to get it for them. The facility was unable to provide a policy regarding where survey results should be located.

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review the facility failed to ensure the nurse daily staffing was posted on a daily basis. this applies to all residents in the facility. The findings include: On 6/25/2026 at 7:30 AM, the facility census and staffing information was not posted in the building. At 7:38 AM, V1 Administrator was asked if the daily staffing and census was posted and she stated to ask V2 Director of Nursing - DON because she was the one to do that. At 7:45 AM, V2 showed what she posts at the back nurses desk and on a clipboard it showed the nurses and certified nurses assignments for the day. V2 was asked where the census was and breakdown of nursing hours etc. she stated she did not know what that meant and that it was not being done. On 7:53 AM, the requirements for posting were gone over with V1 and V2 and it was confirmed that it was not being done. On 6/25/2026 at 11:15 AM, V2 stated she was pretty sure that since they were not posting the staffing that they did not have a policy. The Long term Care Facility Application for Medicare and Medicaid Form - 671 Form dated 6/23/26 showed the facility census as 47 residents.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a bed hold policy and written notice of transfer to 4 of 4 residents (R1,R15,R35,R41) reviewed for hospitalizations in the sample of 23. The findings include:1) R1's facility assessment dated [DATE] showed R1 has no cognitive impairment. R1's nursing progress notes dated 2/12/26 showed R1 was sent to the local hospital for blood in his urine. On 6/25/26 at 10:07 AM, R1 stated, If you go to the hospital, they give you a folder with paperwork in it, but I don't know what is in it. That all goes to the hospital staff. R1's nursing progress notes showed no documentation that R1 was provide the facility bed hold policy or written notice of transfer. 2) R15's facility assessment dated [DATE] showed R15 has no cognitive impairment. R15's nursing progress notes showed R15 was sent to the local hospital on 4/12/26 and 5/14/26. No documentation was present in R15's progress notes showing that R15 was provided a bed hold policy or written notice of transfer. 3) R35's facility assessment dated [DATE] showed R35 has no cognitive impairment. R35's nursing progress notes dated 4/17/26 showed R35 was sent to a local hospital for abdominal distention and tenderness. R35's nursing progress notes for 4/17/26 showed no documentation present that R35 received the facility's bed hold policy & notice of transfer. On 6/25/26 at 9:44 AM, R35 stated, I don't recall getting any paperwork when I went to the hospital. They give you a folder but I don't know what's in it. I didn't know what all of the paperwork was. I would be upset and anxious if I didn't know if I could come back to the facility or not. 4) R41's facility assessment dated [DATE] showed R41 has moderate cognitive impairment. R41's nursing progress notes dated 2/16/26 showed R41 was transported to the local hospital for seizure like activity. R41's progress notes showed no documentation that R41 or her representative was given the bed hold policy or written notice of transfer. On 6/25/26 at 9:26 AM, V2 (Director of Nursing) stated, When a resident goes to the hospital, the paperwork sent with the resident does include bed hold and notice of transfer policy. It is all put in an envelope and sent to the hospital. I thought it was given to the resident, but I could be wrong. I guess if we are putting it all in the same envelope as all of the resident's paperwork, that is all just going to the hospital staff. They don't know to give the bed hold policy and notice of transfer to the resident or family. The facility's undated policy titled, Bed Hold Policy showed, When hospital transfers occur, the nurse will provide the resident and/or family member or legal representative with a copy of this policy and have the resident or legal representative sign the bed hold authorization form. In the event of an emergency transfer, a copy of the bed hold policy will be sent with other paper accompanying the resident and the copy for the resident's family member or legal representative will be mailed the next business day .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a wheelchair to enable a resident to self-propel for 1 resident (R19), failed to provide foot pedals for a resident's (R19) wheelchair. These failures apply to 1 of 1 residents reviewed for accomodation of needs in the sample of 23. The findings include:R19's electronic face sheet dated 6/25/26 showed R19 has diagnoses including but not limited to epilepsy, hypertension, cerebral palsy, and dementia without behaviors. R19's facility assessment dated [DATE] showed R19 has severe cognitive impairment, utilizes a manual wheelchair, and requires partial/moderate assistance to wheel 50 feet with 2 turns. On 6/23/26 at 11:53 AM, R19 was sitting up in her wheelchair at the lunch table with her feet dangling from the wheelchair. R19 was unable to touch the floor with her feet while seated in the wheelchair. At 12:42 PM, staff wheeled R19 upstairs in the wheelchair with no foot pedals on the wheelchair and R19's feet still dangling from the wheelchair. On 6/24/26 at 11:18 AM, R19 was being pushed in her wheelchair to the dining room. R19's feet continued to dangle down from her wheelchair. R19's room was observed and no foot pedals were located in R19's room. On 6/25/26 at 11:55AM, V2 (Director of Nursing) stated, (R19) can self-propel in here wheelchair. I have not seen her with any foot pedals on her wheelchair before but if staff are pushing her in her wheelchair then her feet shouldn't be dangling down. She needs to have foot pedals and a wheelchair where she can touch the floor so that she can propel herself better and use her feet if she wants to. If a resident does not have foot pedals and they suddenly decide to put their feet down then that poses a risk for them to fall out of the wheelchair. Either way, her wheelchair is not appropriate for her. The facility was unable to provide a policy regarding safe use of a wheelchair.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to attempt a reduction of a resident's restraint and release the restraint when supervised for 1 of 1 residents (R3) reviewed for restraints in the sample of 23. The findings include:On 6/23/2026 at 10:02 AM, V9 (R3's power of attorney) stated she did not think R3 needed the seat belt any longer; she did not feel it was necessary. V9 stated it would suit her fine if they got rid of the seatbelt. V9 stated R3 used to scoot in her padded wheelchair but she doesn't see her do that anymore. On 6/24/2026 at 11:19 AM, R3 was up in her padded wheelchair at the dining room table for lunch. R3 had her seatbelt in place and her protective helmet on. At 11:21 AM, R3's food was served. V13 Certified Nursing Assistant - CNA removed R3's protective helmet, put a clothing protector on her, and sat down to assist R3 with lunch. V13 stated they remove the helmet at lunch. The seatbelt remained in place during lunch. V13 stated she thinks R3's new padded wheelchair was helping her with her positioning. V13 stated R3 rarely scoots anymore; they only had to reposition her once earlier. The Face Sheet dated June 2026 for R3 showed medical diagnoses including epilepsy, acute kidney failure, intellectual disabilities, unspecified lump in breast, dysphagia, osteoporosis, profound intellectual disabilities. The Progress Notes for R3 dated 1/1/26 - 6/23/26 did not show any falls from the resident's padded reclining wheelchair. The Restraint Reduction assessment dated [DATE] for R3 showed dated of review as 10/7/25 and stated R3 uses a seatbelt while up in her wheelchair, she has poor trunk control, spastic, involuntary movements and seizures. She has intellectual disabilities and epilepsy; she continues to require the use of the lap belt when she is up in her wheelchair. She is laid down between meals for at least 10 minutes every day and it is released under direct supervision (ie. while cares are rendered). Her mother is highly involved in her care and does release her seatbelt when she is with her also. The Care Plan dated 5/1/26 for R3 showed R3 has a diagnosis of epilepsy. Potential for seizure activity. R3 needs a lap belt on when she is left unattended, while in her wheelchair. R3 has diagnoses of epilepsy and profound intellectual disabilities. R3 is unable to stand or sit unsupported, her last fall was 10/9/25; R3 does continue to have spastic, uncontrolled body movements at times. A lap belt and helmet are used when R3 is left unattended in her wheelchair R3 needs her lap belt and helmet in place when she is left unattended in her wheelchair. On 6/24/2026 at 1:07 PM, V2 Director of Nursing stated, R3 has been in a padded wheelchair for awhile and she just got a new one. V2 stated R3's seatbelt should be released at least every two hours. V2 stated the seatbelt is released when R3 is supervised. V2 reviewed the April 2026 Restraint Reduction Assessment and confirmed the date in the assessment was 10/7/25; she stated that she just copied and pasted the assessment. V2 stated R3's epilepsy diagnosis has not changed so they have not tried to reduce the restraint. V2 stated V9 wants the seatbelt in place. V2 stated R3's last seizure was sometime last year. V2 confirmed that R3 is not moving around like she used to and R3 is on hospice. The facility's Physical Restraint policy (no date) showed the need for a restraint will be re-evaluated at least quarterly to determine their continued need and efforts will be made to eliminate their continued use.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain weekly weights as ordered by the physician for 1 of 1 resident (R43) reviewed for quality of care in the sample of 23.The findings include:The findings include:R43s admission records show he was admitted to the facility on [DATE] with multiple diagnoses including but not limited to chronic diastolic (congestive heart failure). R43s June medication review report shows an order for weekly weights on Monday, for fluid retention to begin on 5/25/26.The Weights and Vital summary dated 6/25/26 shows on 5/10/26 at 156 pounds, and the next weight was completed on 6/7/26 was 168.7 pounds, and 6/11/26 at 165.3 pounds.The June Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed, and the weekly weight order was not listed.On 6/25/26 at 8:46 AM, V2 Director of Nursing (DON) said when an order for weekly weights is received, the nurse should put the order on the MAR. V2 looked into the computer and said the order was put under standard other which will just put the order in the chart, and it was not put in correctly and did not trigger the nurses to complete the weight. The weights should have been done to ensure R43 was not in fluid overload with his congestive heart failure.On 6/23/26 at 2:15 PM, R43 was observed to be sitting up in his wheelchair, had oxygen per nasal cannula. He stated he wears oxygen all the time as he gets short of breath.The facility undated policy for weights documents they are to obtain and document resident's weight accurately upon admission and thereafter by following standard protocol and procedures. Systematically and accurately identify any significant weight changes and implement appropriate instructions in a timely manner.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a restorative program tailored to a resident's needs for 1 of 2 residents reviewed for restorative therapy in the sample of 23. The findings include:R18's electronic face sheet dated 6/25/26 showed R18 has diagnoses including but not limited to frontotemporal neurocognitive disorder, dysphagia, repeated falls, and depression. R18's facility assessment dated [DATE] showed R18 has severe cognitive impairment and receives restorative therapy R18 had no care plan related to restorative therapy or his need for assistance with transfers/ambulation. R18's restorative task for June 2026 showed, Walk towards the elevator and back towards the room with gait belt, walker, and 2 assist, remind him to keep walker close to him. He does get tired. On 6/23/26 at 9:58 AM, V5 and V8 (Certified Nursing Assistants-CNA's) assisted R18 to the bathroom. Both V5 and V8 stated R18 might take a few steps here and there but nothing more. Both staff stated they do not do any other restorative therapy with R18 because it's not on their task list to do anything else with him. On 6/25/26 at 9:20 AM, V2 (Director of Nursing) stated, I am in charge of restorative and I am the Director of Nursing. I have been doing both positions for a year and a half. My restorative CNA is working the floor because of staffing so things are lacking. We are supposed to do a walk to dine program and the aides on the floor don't have time to get to everyone. I don't know that (R18) is on restorative programming that works for him. We attempt to walk, but he does not do it near as much as he was. His sister still wants us to attempt and we can usually get him a few steps. He does not receive passive range of motion or anything like that. He is one that should be on a program because he is getting increasingly stiff and we need to keep him moving as best as we can for as long as he is able to do it. The facility's undated policy titled, Restorative Programming showed, Objectives: to decrease or prevent contractures and/or atrophy, increase circulation, improve strength and movement, to ensure the resident can participate to the best of their ability in ADL's (Activities of Daily Living), providing holistic care by staff .

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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 ensure a resident was transferred using a gait belt and failed to ensure a resident was safely transported in a wheelchair for 2 of 6 resident (R43, R9) reviewed for safety in the sample of 23. The findings include: 1. R43s admission record shows he was admitted to the facility on [DATE] with multiple diagnoses including but not limited to congestive heart failure, and mild protein-calorie malnutrition. The 3/17/26 care plan for R43 identifies him as a risk for falls. The interventions show he requires the assistance of one staff using a gait belt for transfers.On 6/23/26 at 2:00 PM, V5 Certified Nursing Assistant (CNA) pushed R43 towards the bathroom. Standing behind the wheelchair she leaned over and assisted R43 to stand up without placing a gait belt around his waist. He stood, turned and sat down on the toilet. When he was finished, V5 then placed a gait belt around his waist to assist him back to the wheelchair. She stated R43 required one assist but only with supervision and did not always need the gait belt. On 6/25/26 at 8:43 AM, V2 Director of Nursing (DON) said R43 transfers with the assistance of 1 staff with a gait belt. The gait belt will provide leverage should he begin to fall during the transfer. The facility's 5/22/25 policy for gait blet/1-assist transfers documents Gait belts are used as a safety measure for both staff and residents in any of the following situations: 1. Transfer (all phases) of a resident.2. On 06/23/26 at 12:23 PM, R9 was observed to be pushed down the hallway by V8 CNA. The wheelchair had no pedals in place, and R9 was holding his feet off the floor.R9s Resident Assessment and care screening of 4/29/26 shows he has severe cognitive impairment. The same assessment also shows he uses a wheelchair for mobility and requires partial/moderate assistance for transfers. The assessment documents he does have a history of falls.On 6/25/26 at 9:02 AM, V2 said normally R9 will propel himself with his feet. But while the staff are pushing him, if he were to put his feet down during the transport he would fall out of the chair. The facility's 5/2026 policy for falls documents HEAR ME fall prevention strategy: H- Hazards. Environmental hazards should be identified, addressed and corrected promptly. M- Materials and Equipment. Ensure all equipment and assistive devices are functioning properly and used appropriately.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility failed to ensure cathter bags were covered and not resting on the floor for 2 of 2 residents (R2 & R21) reviewed for catheters in the sample of 23. The findings include:1. On 6/23/2026 at 10:21 AM, R21 was in a low bed to the floor. R21 had a catheter drainage bag on the side of bed with no cover on the bag and the bag was laying on the floor. On 6/23/2026 10:25 AM, V10 certified nursing assistant - CNA went into R21's room and stated the drainage bag should not be on the floor for infection control. V10 stated there should be a dignity bag to keep out of site and off the floor, also for infection control. On 6/25/2026 at 8:30 AM, V2 director of Nursing - DON sated the bag/covers for the catheter bags are used for dignity and to keep the drainage bag off the floor for infection control. V2 stated drainage bags should not be on the floor or touching the floor for infection control. The Face Sheet dated 6/25/26 for R21 showed diagnoses including multiple sclerosis, retention of urine, ventricular tachycardia, atherosclerotic heart disease, hypertension, chronic kidney disease stage 3, type 2 diabetes mellitus, hyperlipidemia, and traumatic subarachnoid hemorrhage. The Physician Orders dated June 2026 for R21 showed catheter care every shift. The Care Plan dated 6/22/26 for R21 showed R21 has a catheter related to urine retention. The catheter is a 16 French with a 10 cc balloon. Do not allow tubing or any part of the drainage system to touch the floor. Store collection bag inside a protective dignity pouch. The facility's Catheter Care Policy (no date) showed keep the collection bag (port opening) and tubing off the floor. 2. On 6/23/2026 at 10:16 AM, R2 was in bed on her back and had an indwelling urinary catheter drainage bag hanging on the lower part of her bed facing the entrance/hallway to the room. There was darker yellow urine that is cloudy and sediment present. On 6/25/2026 at 8:30 AM, V2 director of Nursing - DON sated the bag/covers for the catheter bags are used for dignity and to keep the drainage bag off the floor for infection control. V2 stated drainage bags should not be on the floor or touching the floor for infection control. The Face Sheet dated 6/24/26 for R2 showed diagnoses including heart failure, vascular dementia, cerebrovascular disease, retention of urine, major depressive disorder, dyspnea, vertigo, hypertension, dizziness and giddiness, hyperlipidemia, stress incontinence, cardiac murmur, and anxiety disorder. The Physician Orders Dated June 2026 for R2 showed she has a 20 French catheter with a 10 cc balloon. Catheter care every shift. The Care Plan dated 5/19/26 for R2 showed she has a catheter related to urine retention. Store collection bag inside protective dignity pouch.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to apply oxygen as ordered by a physician for 2 resident (R19,R49), failed to maintain oxygen concentrator per manufacturer's recommendations for 1 resident (R49), failed to change oxygen tubing per facility policy for 1 resident (R43). These failures apply to 3 of 3 residents reviewed for oxygen therapy in the sample of 23. The findings include: 1) R19's electronic face sheet dated 6/25/26 showed R19 has diagnoses including but not limited to cerebral palsy, epilepsy, dementia without behaviors, Alzheimer's disease with late onset, dysphagia, and hypertension. R19's facility assessment dated [DATE] showed R19 has severe cognitive impairment. R19's physician's orders dated 5/30/26 showed, Oxygen 2-3L (liters) per NC (nasal cannula) as needed for resident. R19's progress note dated 6/1/26 showed, Continue oxygen 3L. Her oxygen level goes down while in bed. R19's care plan showed no care plan was developed for R19 requiring oxygen use. On 6/23/26 at 9:58AM, R19 was lying in bed with her oxygen concentrator turned on at 3L. R19's nasal cannula was under her chin and not providing oxygen therapy to the resident. On 6/23/26 at 10:05 AM, V6 (Registered Nurse) stated, (R19) doesn't have a diagnosis or anything for her oxygen. Her oxygen saturations just drop when she is in bed. Sometimes when she is eating she will put it under her chin but for the most part she keeps it on. She does have a diagnosis of dementia but is usually pretty compliant with everything. On 6/23/26 at 11:37 AM, R19 was sitting up at the lunch table with her nasal cannula tucked under chin and her portable oxygen machine was on at 3L. On 6/24/26 at 10:10AM, R19 was lying in bed with her oxygen concentrator on at 3L and her nasal cannula tucked under her chin. On 6/24/26 at 10:41AM, R19 continued to lay in bed with her nasal cannula no longer able to be visualized while the oxygen concentrator was on at 3L, On 6/25/26 at 9:28 AM, V2 (Director of Nursing) stated, We should be reapplying the oxygen if a resident has an order for it and they are removing it. We cannot force them to wear it, but we should be encouraging them to wear it. If it is a constant issue, we would talk to the physician and family about discontinuing it. The facility's undated policy titled, Oxygen Administration showed, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences .1. Oxygen is administered under orders of a physician . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 6/23/2026 at 9:51 AM, R49 was in bed on his back with the prongs of the nasal canula in his mouth. R49 had oxygen on at 4 liters per nasal canula. The humidification bubbler on the concentrator was 1/4 of the way full. The oxygen tubing and bubbler were not dated. The oxygen concentrator was missing a filter on the back of the machine; the holder where the filter sits was empty. On 6/23/2026 at 10:30 AM, V11 Licensed Practical Nurse - LPN stated she doesn't know anything about the filters on the concentrators and doesn't know who cleans them or maintains them etc. On 6/24/2026 at 1:07 PM, V2 Director of Nursing - DON stated that the filters on the oxygen concentrators were taken care of by the maintenance department. Then hospice would take care of the hospice ones. A company comes out once a year to check their machines. V2 stated that nursing doesn't do anything with the concentrator filters and they never have. V2 did not have any information on routine cleaning/maintenance of the filters on the oxygen concentrators etc. The Face Sheet dated 6/24/26 for R49 showed diagnoses including malignant neoplasm of unspecified part of unspecified bronchus or lung, dementia, retention of urine, depression, hypertension, hypothyroidism, chronic kidney disease, atrial flutter, hyperkalemia, hypo-osmolality and hyponatremia. The June 2026 Treatment Administration Record - TAR for R49 did not show anything about cleaning the oxygen filters on the concentrator/maintenance of the concentrator. The Care Plan dated 4/30/26 for R49 showed R49 has end stage disease, 6 or fewer months to live related to lung cancer. He is currently receiving hospice care. R49's care plan did not show any interventions related to the oxygen concentrator. The facility's blank Oxygen Concentrator Service and Maintenance Log form showed cabin air filter - clean weekly. Preventative maintenance check - inspect filters and replace as necessary. 3. On 6/23/26 at 9:57 AM, R43 was observed sitting in his wheelchair with his nasal oxygen cannula sitting on his ear, and not in his nose. The long tubing had a piece of tape dated 6/2/26. On 6/23/26 at 10:10 AM, V5 CNA said R43 should have his oxygen all the time. V6 RN said the oxygen tubing is changed every 2 weeks. The order comes up on the treatment record. The whole system, including the bottle of water, is changed every month. V6 looked at the tubing and stated she was the nurse who changed it, and she had signed the 6/2/26 tubing. V6 said it should have been changed. On 6/25/26 at 8:40 AM, V2 stated the tubing should have been changed after 2 weeks. The facility's oxygen therapy policy states H. Change nasal cannula/and or mask every 14 days, extension tubing every 30 days.

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	06/25/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform glove changes during wound care for 1 resident (R7), and failed to wear personal protective equipment during wound care for 1 resident (R15). These failures apply to 2 of 5 residents reviewed for infection control in the sample of 23, The findings include: 1) R7's electronic face sheet dated 6/25/26 showed R7 has diagnoses including but not limited to heart failure, pressure ulcer stage 4, type 2 diabetes, cystostomy status, pressure ulcer stage 3, and colostomy status. R7's facility assessment dated [DATE] showed R7 has no cognitive impairment and has 2 pressure ulcers. R7's care plan dated 3/24/26 showed, (R7) is at high risk for skin breakdown. He has a foley catheter and a colostomy. (R7) is a 1-2 assist with transfers and uses a wheelchair for mobility. (R7) was admitted to this facility with a stage 4 pressure ulcer to his coccyx, breakdown to his left posterior thigh and excoriation to his perineum and groin. (R7) also has a stage 2 pressure ulcer to his right gluteal fold with treatment in place. On 6/24/26 at 10:19 AM, V7 (Registered Nurse) provided wound care to R7. V7 applied a gown and gloves, removed the soiled dressing from R7's coccyx wound, cleansed the wound with wound cleanser, sprinkled metronidazole inside the wound, packed the wound, and applied a new dressing without changing her gloves. V7 removed her gloves and applied a new pair of gloves with no hand hygiene in between glove changes. V7 removed the soiled dressing from R7's buttocks, cleansed the wound with wound cleanser, applied calcium alginate to wound bed and covered the wound with a dressing without changing her gloves between cleaning the wound and applying a clean dressing, V7 then changed her gloves without performing hand hygiene in between glove changes and applied a barrier cream to R7's scrotum. V7 stated, I didn't realize that I didn't change my gloves in between dirty and clean. I thought I just had to change them between the wounds.: On 6/24/26 at 11:55AM, V2 (Director of Nursing) stated, Glove changes should be performed in between dirty and clean tasks. If a nurse is performing a dressing change, they should be removing the old dressing, cleaning the wound, performing hand hygiene, applying new gloves, and then applying the clean dressing to ensure no cross contamination occurs. The facility's policy titled, Glove use dated 3/1/10 showed, E. Wash hands after removing gloves. Gloves do not replace hand washing. F. Disposable (single use) gloves should be replaced was soon as practical when contaminated . 2. On 6/24/26 at 7:58 AM, V12 Registered Nurse - RN was at R15's bedside for dressing changes to his bilateral lower extremities. There was an enhanced barrier precaution magnet on his door. V12 had gloves on but did not have a gown on. V12 removed the elastic bandage, and dressing from R15's right lower leg. V12 cleansed R15's right lower leg and right posterior thigh using a cleanser on 4 x 4's. V12 held R15's leg up at times next to her body in order to re-apply the dressings and elastic bandages to his right lower leg and thigh. V12 removed the elastic bandage and dressings from R15's left lower leg. V12 used a cleansing solution on 4 x 4's and cleaned the macerated skin on his left foot. V12 cleansed between his toes and under them. V12 applied gauze between his toes, applied and (continued on next page)

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	145495	A. Building B. Wing	06/25/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abdominal pad over the top of his left foot, and wrapped his foot and lower leg with kerlix. V12 stated R15's the skin on his left foot appeared to be macerated. On 6/25/2026 at 10:55 AM, V2 Director of Nursing - DON stated enhanced barrier precautions (EBP) is for anyone with an opening, catheter, tubes etc. Staff should wear gown and gloves with care. V2 stated there are magnets on the doors that are the same as the actual signage. V2 stated staff are to follow what the signage states if it is posted. The Face Sheet dated 6/25/26 for R15 showed diagnoses including cellulitis of left lower limb, congestive heart failure, bipolar disorder, hypertension, morbid obesity, peripheral vascular disease, restlessness and agitation, type 2 diabetes mellitus, venous insufficiency, carrier of carbapenem resistant acinetobacter baumannii, gastroesophageal reflux disease, benign prostatic hyperplasia, obstructive and reflux uropathy, and hyperlipidemia. The Physician Orders dated June 2026 for R15 showed cleanse right posterior thigh with wound cleanser, air dry, wrap with kerlix and ace wrap entire thigh. Left lower extremity and right lower extremity, cleanse with wound cleanser, air dry, wrap with kerlix followed by ace wrap twice a day (clean with hydrogen peroxide only if maggots are present). Enhanced barrier precautions due to wounds/extensively drug-resistant organism. The Care Plan dated 6/24/26 for R15 showed, R15 is at high risk for skin breakdown. R15 was admitted with wounds to his bilateral lower extremities due to peripheral vascular disease. There were no interventions on the care plan regarding enhanced barrier precautions. The Wound assessment dated [DATE] for R15 showed vascular wounds with the following description: left top of foot with some maceration noted The facility's Enhanced Barrier Precautions policy (February 2026) showed enhanced barrier precautions will be used for residents with indwelling medical devices, wounds, or those who are colonized or infected with multi-drug resistant organize. At a minimum gloves and gown must be worn during high contact tasks with affected residents.