STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006019	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDINA NURSING CENTER	402 SOUTH CENTER STREET DURAND, IL 61024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Survey: 2410287/IL168630	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	S9999		

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S9999	Continued From page 1	S9999		

These Requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident was supervised and assisted as needed by staff while ambulating which contributed to R1 falling in the facility and sustaining a right hip fracture. This failure applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 6.

The findings include:

The facility's Fall-Initial Documentation note dated 1/7/24 showed R1 fell while walking, by herself, in the dining room of the facility. The note showed R1's fall was witnessed by V7 Dietary Aide and V8 Nurse Manager. The note showed R1 was walking with a walker when "she was trying to move her legs but legs would not move. Resident then lost her balance and fell on her right side." Upon examination, R1's right leg appeared shortened and rotated. R1 complained of pain to her right hip. 911 was called. R1 was sent emergently by ambulance to a local hospital. R1's hospital records dated 1/7/24-1/11/24 were reviewed. The records showed R1 was admitted to the hospital, on 1/7/24, with a diagnosis of an intertrochanteric fracture of her right hip. R1 had surgery on 1/8/24 to fix/treat her right hip fracture. R1 was discharged from the hospital, back to to the facility, on 1/11/24.

R1's Fall Risk Assessment dated 10/12/23 showed R1 was at risk for falls due to her history of previous falls, diagnoses of dementia, Alzheimer's disease, psychotic disturbance, and her impaired cognition.

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S9999	Continued From page 2	S9999		

R1's electronic medical records showed R1 had sustained previous falls in the facility on 11/15/23, 3/1/23, and 2/7/22. The records showed R1 fractured her right ankle as a result of her fall on 2/7/22.

R1's care plan dated 10/2/23 showed R1 "was at risk for falls due to her unsteady gait and impaired balance." The care plan showed R1 "will participate in a Walk N' Dine program by walking to and from the bathroom and from her room to the elevator prior to meals with the use of her front wheeled walker, stand by assist of one (staff) and wheelchair to follow by her..."

On 1/16/24 at 9:15 AM, this surveyor attempted to interview R1 about her fall on 1/7/24 but was unable to complete the interview due to R1's impaired cognition.

On 1/16/24, two attempts to contact V7 Dietary Aide for an interview related to R1's fall were unsuccessful.

On 1/16/24 at 12:10 PM, V8 Nurse Manager stated, "Stand by assist with a wheelchair means staff are to stand next to the resident, with a wheelchair, when the resident is walking, in case the resident needs help or needs to sit down. I didn't realize (R1's) care plan showed that (R1) needed that assistance when walking. No one was walking with (R1) when she fell (on 1/7/24). She was in the dining room when she fell. I was right outside the dining room, passing medications to another resident, when it happened. I heard (V7 Dietary Aide) yell, 'She's going to fall.' I turned around and saw (R1). Her legs were twitching, she stopped walking, and she went down. I couldn't get to her in time. (R1) was using her walker when she fell. The only

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S9999	Continued From page 3 staff around when (R1) fell was me and (V7)..." On 1/16/24 at 12:47 PM, V9 Nurse Practitioner stated, "(R1) has had previous falls in the facility. In fact, I know she broke her ankle one time due to a fall. I really have never seen her walk. When I see her, she is always in her wheelchair. I know she requires staff assistance with transfers. Her care plan should be followed. For her safety, if her care plan says she should walk with staff walking by her with a wheelchair, then that's what staff should be doing." (A)	S9999		