STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145713	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momence Meadows Nursing & Rehab	500 South Walnut Momence, IL 60954

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395 Based on observation, interview, and record review, the facility failed to ensure that a resident was free from abuse for one of three residents (R3) reviewed for abuse in a sample of 3. This failure resulted in R3 being physically slapped by a staff member which caused R3 to experience emotional distress and led to R3 displaying increased agitation, aggression, and combative behavior. Findings include: R3's face sheet indicated that resident admitted to the facility on [DATE] and has a past medical history not limited to: cerebral infarction due to thrombosis, metabolic encephalopathy, bipolar disorder, personal history of physical injury and trauma, and tension-type headaches. R3's screening assessment for indicators of aggressive and/or harmful behavior dated 09/16/2024 revealed that R3 is at minimal risk for aggression with dementia, related interventions of re-orientation, re-assurance, emphasis on safety/security, and severe mental illness interventions of stress management/relief and harm reduction. Review of R3's active physician's orders summary on 01/21/2025 showed the following: divalproex sodium delayed release 125 milligram (mg), give 2 capsules by mouth three times a day for manic depression with start date of 10/11/2024; topiramate 50 mg tablet, give 1 tablet by mouth two times a day for bipolar disorder with start date of 10/24/2024; trazodone hcl 50 mg, give 1 tablet by mouth at bedtime for depression, insomnia. The facility's final report with incident date of 10/22/2025 indicated that the facility had conducted an investigation of physical contact made to R3 by staff member V3 (Certified Nursing Assistant). The facility substantiated the alleged act based on witness reports that revealed V3 (CNA) was observed striking R3 on the hand when R3 attempted to grab at V3's laptop. R3 responded by hitting V3 (CNA). Review of R3's Minimum Data Set (MDS) Section C - Cognitive Patterns documented a Brief Interview for Mental Status (BIMS) score of 08/15 dated 12/11/2024 that indicated moderate cognitive impairment. On 01/21/2025 at 10:30 AM, R3 was observed in his wheelchair across from the 200 unit nurse's station. R3 appeared to be in a calm and pleasant mood and did not recall the physical abuse incident. (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 01/21/2025 at 10:35 AM, V4 (Certified Nursing Assistant) said R3 can get agitated at times due to loudness or if someone bumps into him for example. V4 added that she has never seen R3 be aggressive with staff because his arms can be stiff, almost contracted at times. On 01/21/2025 at 12:06 PM, V1 (Administrator) said on the date of incident, V3was assigned to R3 for 1:1 monitoring and was told to take R3 into the dining room. While in the dining room, R3 was attempting to reach for V3's personal laptop that she should not have had with her at work. V3 was observed by staff members V5 (Restorative Nurse) and V7 (Activity Aide) slap R3's hand away then R3 punched V3 in the face. V1 (Administrator) then said that V3 was immediately removed from the dining room and suspended pending the outcome of her investigation. V1 added that she always tells staff they cannot hit a resident under any circumstances and that V3 should have called for assistance, attempted to redirect R3, and/or should have removed her laptop from R3's immediate area. V1 (Administrator) then said that V3 was terminated because the abuse allegation was substantiated. V1 added that R3 was not sent out to be evaluated. On 01/21/2025 during interview from 12: 28 PM to 12:40 PM, V5 said she was standing in the doorway of the main dining room and facing inside the room where she observed R3 sitting in the dining room at a table seated next to V3. V5 then said that she saw R3 was grabbing at V3's laptop then V3 had pushed R3's hand away, but R3 kept grabbing for the laptop. V5 then saw V3 slap R3's left hand with her right hand, and R3 immediately punched V3 in the face. V5 approached the table and informed V3 that V10 (Registered Nurse) would stay with R3. V5 then said that she escorted V3 to V2's (Director of Nursing) office and informed V2 of the incident. V5 added that R3 has a known behavior to get nervous and react when people don't explain things to him, approach him with a loud tone, or if they rush R3 to do tasks. V5 then said that V3's behavior was not appropriate because staff should not use physical methods to redirect a resident. V5 added that V3's slap triggered R3's aggression towards her. On 01/21/2025 at 12: 44 PM, V6 (Assistant Director of Nursing) said around 02:30 PM on day of incident, she was standing in the doorway of the dining room but was facing towards the hallway. V5was standing next to her facing inside the dining room when she heard a slap sound. V6 added that V5 then turned to her (V6) and said, did you see that, she just slapped him on the hand like he was a kindergartener. V6 then said after she heard the slap sound, she turned around and saw R3 hit V3 in the face. V6 approached V3 and told her to go to her office, then briefly assessed R3 for any apparent injuries before reporting the incident to V1 (Administrator). V6 added that if staff interact with R3 in an aggressive manner, he will become aggressive. Staff must talk to him in calm manner, then said R3's voice became louder after V3 slapped him. V6 also said that staff who are familiar with R3 are knowledgeable of this calm approach, and that V3 normally worked with him and knew about his temperament. On 01/21/2025 during interview from 1:01PM to 01:10 PM, V10 (Registered Nurse) said V3 was in the dining room with R3 on day of incident and he was R3's nurse. V10 said as he approached the dining room to relieve V3 for a meeting, he saw V5 and V6 standing in the doorway and heard V5 saying that V3 had hit R3. V10 then said he observed R3 beginning to calm down as V3 was being removed from the dining room. V10 added that R3 is much calmer now and has had no further issues since the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 01/21/2025 at 01:25 PM, V3 said she was assigned to R3 for 1:1 monitoring. V3 said she took him into the dining room, put him up to a table, and had put the wheel locks on to the wheelchair, V3 then sat down next to him, but he kept trying to unlock the wheelchair and slapped at her hand when she tried to cover the wheelchair lock with her own hand. V3 then said R3 started digging his nails into her wrist, forearm, and right hand and then began digging harder so she slapped her own forearm to get R3 to understand that he was hurting her. V3 said R3 then punched her in the face with a closed fist. V3 added that R3 can have aggressive behaviors but she did not call out for assistance and knows that hitting residents isn't allowed. V3 then indicated that V13 and V7 were both present in the dining room and had both observed the incident then indicated that V13 no longer is employed at the facility. V3 then said she was told by V6 that there was an allegation of abuse by V3 towards R3, so she was walked out of the facility and then terminated on 10/29/2024 because the abuse allegation was substantiated. Review of V3's employee disciplinary action form dated 10/29/2024 revealed that V3 was terminated due to an allegation of physical abuse of physical abuse towards a resident was substantiated. Review of V13's (Certified Nursing Assistant) signed confidential witness statement dated 10/28/2024 revealed that V13 did not personally observe the incident between R3 and V3 (CNA). On 01/21/2025 at 2:09 PM, V7 said at about 03:00 PM on day of the incident, V3 was in the dining room with R3 and that he (V7) was nearby them and could see that V3 was trying to prevent R3 from standing up from his wheelchair. V7 then said after a few minutes, R3 was getting agitated, and it looked like he was scratching at V3's (CNA) arm when he then saw V3 slap R3's hand then R3 punched V3 in the face immediately afterwards. V7 added that after V3 was removed from the area, R3 then began to calm down. Review of undated employee roster on 01/21/2025 showed that V3 and V13 are not currently employed at the facility. Review of Abuse Prevention Program policy on 01/21/2025 that was last revised 01/2019 reads in part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against in the facility. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party. Protection of Residents: the facility will take steps to prevent mistreatment while the investigation is underway. Residents and visitors are protected from any retaliation or possible harm. Staff members who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and suspended from duty, pending the outcome of the investigation, prosecution or disciplinary action against the employee. Prevention: The facility desires to prevent abuse, neglect, misappropriation, and a crime against a resident by establishing a resident-sensitive and resident-secure environment. This will be accomplished by a comprehensive Quality Assurance Performance Improvement approach. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Abuse and Crime Reporting: this facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends or other individuals. For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse: hitting slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. After notification of alleged abuse, neglect or a suspected crime against a resident, the administrator or DON in the administrator's absence shall immediately commence an investigation of the incident reported. The findings of such investigation will be provided to the administrator within 5 working days of the occurrence of such incidents. The administrator shall either rule-out or substantiate the allegation of abuse. The administrator or DON shall review the findings of the investigation and determine if further training or other corrective action is needed to prevent future occurrences.