

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER Momence Meadows Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36567</p> <p>Based on interviews and record review, the facility failed to prevent resident to resident abuse.</p> <p>This applies to 2 of 5 residents (R2 and R3) reviewed for abuse in the sample of 10.</p> <p>The findings include:</p> <p>1. FRI (Facility Reported Incident) report documents an incident of April 14, 2025, alleging that R1 made inappropriate contact with R2. The report indicates that immediate action taken: Residents were immediately separated. Body and pain assessments completed on R1 and R2. Police was notified. R1 was placed on 1:1 monitoring until sent out to the hospital for further evaluation. After interviewing staff and residents, it was discovered that R1 and R2 were waiting in the hallway to go out for smoke break but staff did not witness the incident.</p> <p>R2's EMR included diagnoses of End Stage Renal Disease; Chronic Obstructive Pulmonary Disease; Major Depressive Disorder, Recurrent; Unspecified Bipolar Disorder, Schizoaffective Disorder unspecified</p> <p>R2's Admission MDS dated [DATE], showed that R2 was cognitively intact.</p> <p>R1's EMR (electronic medical records) included diagnoses of other Lack of Coordination; Hypothyroidism, Unspecified; Dementia In Other Diseases Classified Elsewhere, Moderate, With Other Behavioral Disturbance; Weakness; Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris.</p> <p>R1's quarterly MDS (minimum data set) dated April 14, 2025 showed that R1 was moderately impaired cognition.</p> <p>On May 1, 2025 at 10:20 AM, R2 stated that she doesn't remember the date or time of the incident. R2 continued We were lining up for smoke break. He (R1) came out of his room and came by me and said Hi and I said Hi. I have always said Hi (previously). This time he decided to touch me on my breast. He was just rubbing across. Then he decided that he was going to move his hand down below on my vagina through my clothes and I smacked is hand and said 'No.' He didn't stop. That was the end of it as they (staff) were to open the door, and he stopped as he didn't want to get caught. I went to V7 (Activity Aide), who opened the door and came to hand out the cigarettes. But she didn't see it. She told somebody who was over her about it and I guess they send him to the hospital for a while .</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 1, 2025 at 10:39 AM, V4 CNA (Certified Nursing Assistant) was seen seated outside R1's door and stated that R1 is on 1:1 monitoring since he got back from the hospital on April 19, 2025. V4 continued He has had two or three incidents of inappropriate touching of other residents. It was R5 and another resident who is no longer here. That resident did not report it until she was getting to leave at the door. I don't know if those incidents happened. He (R1) has been on 1:1 monitoring after each incident</p> <p>On May 1, 2025 at 11:36 AM, V1 stated that during investigation, R2 stated that while she was in line to go for cigarette break, R1 touched her breasts and tried to touch her vagina area and that she pushed his hand away. V1 stated that there were no more witnesses of the incident so it was not substantiated. V1 continued that R1 had had another allegation against him on November 15, 2024 alleging that he was touching another resident on the breasts which was witnessed by a Dietary staff. V1 added that this was investigated by IDPH and cited for the same. V1 stated that as a precautionary measure, R1 is placed on 1:1 monitoring until facility finds an alternate placement for him.</p> <p>2. FRI (Facility Reported Incident) report included that R4 made physical contact with R3 on April 24, 2025.</p> <p>The facility concluded after interviewing staff and residents, that R3 wandered into R4's room and tried to remove some items from his table and R4 tried to stop her. The staff came into the room and removed R3 from the room. R3 and R4 were assessed and noted without pain or serious injury. R3 was noted to have a small skin alteration to her left eyebrow.</p> <p>R3's EMR included diagnoses of Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Generalized Anxiety Disorder. R3's quarterly MDS, dated [DATE], showed that R3 was severely impaired in cognition.</p> <p>R4's EMR included diagnoses of Hypothyroidism, Unspecified; essential (Primary) Hypertension; hyperlipidemia, Unspecified; weakness; dementia in Other Diseases Classified Elsewhere, Mild, With Mood Disturbance; and Anxiety Disorder, Unspecified. R4's quarterly MDS, dated [DATE], showed that R4 was severely impaired in cognition.</p> <p>On May 1, 2025 at 10:20 AM and 10:56 AM, R3 was seen wandering from hallway to hallway. R3 was also seen walking about during activities eating pudding from a disposable container and going from table trying to feed it to other residents or touching them and those residents appeared annoyed. V7 and V8 (both activity aides) stated that R3 is a wanderer. V7 and stated that R3 just walks around and tries to touch people. V8 stated that R3 touches people and some residents say, get away.'</p> <p>On May 1, 2015, at 11:04 AM, R4 was resting in bed and when asked, stated that no residents bothered him. V10 (LPN-Nurse) who was in the vicinity, stated that R4 is confused and not aware of any incidents with other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 1, 2025 at 12:45 PM, R10 stated that R4 is his roommate. [R4] and the other person [R3] who was a female were fighting. I was sleeping and woke up and he was hitting her. They were both down on the floor and were wrestling. He said that she took something of his, and he was trying to get it back. He hit her right by the eye. I went to get V4 (CNA) who was standing by the front desk as I did not want to get involved and everything.</p> <p>On May 1, 2025 at 11:46 AM, V1 stated that R3 had wandered into R4's room and was trying to get something from his over the bed table and he was trying to stop her from getting into his stuff. V1 stated that R4's roommate R10 woke up and ran to get help. V1 continued V4 (CNA) came in there and called for more help and another V5 (CNA) came and got V6 (Licensed Practical Nurse) for more help. V6 took R3 out of the room and assessed her. V4 did not take her out of the room earlier as she was on the floor and she did not want to move her. V6 did a head to toe assessment and R3 had a small scratch over her left eyebrow. R3 has severe Dementia and wanders a lot and means no harm and tends to tap people as she is walking</p> <p>On May 5, 2025, at 3:35 PM, V6 confirmed the above and stated that when she entered the room, R3 was sitting on the floor and R4 was on his bed. V6 stated that when she assessed R3 and observed a scratch on her eyebrow that was bleeding a little bit</p> <p>Facility provided other reportable's for R3 which showed R3's history of wandering and altercations.</p> <p>November 25, 2024: R3 wandered into the dining room and tried to touch things on R9's table and R10 tried to push her away.</p> <p>November 5, 2024 : R3 wandered into R8's room and touched her.</p> <p>September 30, 2024: R3 wandered in the hallway and touched R7.</p> <p>September 24, 2024: R3 wandered into R6's room and touched her.</p> <p>Facility policy and procedure titled Abuse Prevention Program (last revised January 1, 2019) included as follows:</p> <p>Policy: It is the policy of this facility to prohibit and prevent resident abuse.</p> <p>Abuse prevention program:</p> <p>As part of the social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches regularly .</p>		