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	04/15/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect by failing to respond timely to call lights.This applies to 3 of 15 residents (R1, R6, R8) reviewed for call light response time in the sample of 15. The findings include:1.R1 is alert and oriented and was admitted to the facility on [DATE]. R1 has multiple diagnoses including spinal stenosis, congestive heart failure, type II diabetes, cardiomyopathy, hypercholesteremia, atrial fibrillation, anxiety, hyperlipidemia, morbid obesity, functional quadriplegia, low back pain, edema, depression, restless leg syndrome, and need for assistance with personal care.On April 07, 2026, at 11:56 AM R1 said that staff are often slow to respond to call lights, and it takes them awhile to come in to see what they may need if they even come in.2. R6 is alert and oriented and was admitted to the facility on [DATE]. R6 has multiple diagnoses including cerebral palsy, paraplegia, epilepsy, asthma, morbid severe obesity, type II diabetes, schizoaffective disorder, anxiety, anemia, schizophrenia, depressive disorder, psychosis, suicidal ideations and hypertension.On April 08, 2026, at 3:05 PM, R6 said that it takes the staff a long time to respond to call lights. R6 said it can take from thirty minutes to over an hour for a response especially if the assigned certified nurse assistant (CNA) is on break. If the CNA is on a break, then the resident has to wait for the CNA to return. R6 said that another CNA or nurse should be able to respond to the call light if the assigned CNA is busy.3. R8 is alert and oriented and was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disorder, lymphedema, venous thrombosis, hypothyroidism, hypertension, and morbid obesity.On April 07, 2026, at 11:42 AM, R8 said that call light response has been a major concern. R8 said that they are bedbound and rely heavily on staff for all needs. R8 said that if the assigned CNA is busy the resident has to wait. This can be up to a little over an hour.On April 08, 2026, at 3:28 PM a call light alarmed while a nurse sat at the nurse's station unmoved. Activity aids and another nurse walked past the call light before it was answered by a CNA at 3:36 PM.On April 09, 2026, at 12:33PM two call lights were alarming at the nurses' station while two staff members were sitting at the desk. The call light was finally responded to by a CNA at 12:50 PM.On April 09, 2026, at 12:35PM a call button was alarming at the nurses' station. During this time there were several nurses at the nurses' station with V2 (Interim Director of Nursing) who provided an in-service to the nurses. During this time the CNAs were still assisting other residents in the dining hall. At 12:45 PM the call light was still alarming and had not been answered. At 12:50 PM the in-service concluded, and the DON went to their office. The call light remained unanswered. R6 exited the room with a visitor at 12:55 PM. The call light continued to alarm and staff still had not shown up to R6's room to respond. At 12:58 PM the call light had not been answered, during this time housekeeping staff walked past, and CNAs delivered food trays through the halls while nurses sat at the nurses' station. The room was checked and the call light was turned off by a CNA picking up dietary trays at 1:10 PM.On April 10, 2026, at 10:24 AM V12 (Activity Aide) said that CNAs are responsible for answering call lights and sometimes the nurses can answer.On April 10, 2026, at 10:30 AM V27 (CNA) said that everyone is responsible for responding to call lights and that they should be answered as soon as possible. On April 10, 2026, at (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:45AM V14 (LPN) said that everyone is responsible for answering call lights as soon as possible.On April 10, 2026, at 10:49 AM V15(Registered Nurse) said that all staff members are responsible for answering call lights.On April 10, 2026, at 1:30 PM, V2 said that everyone is responsible for answering call lights and that call lights should be responded to as soon as possible. V2 said that response should not be more than twenty minutes anyone can enter to see what the needs are. The facility's Call Light policy showed that it is the policy of the facility to have a system in place to allow the staff to respond promptly to a resident's call for assistance and to ensure that the call system is in proper working order. The facilities procedure showed: 1) all facility staff are to be oriented to the call light system. 2) Call lights are to be answered promptly by staff who see that the call light has been activated. 3) Even if unable to meet the needs of a resident, staff should report the need to the appropriate staff member. 4) Bedside call lights are seen and heard above the door of the residents' rooms and at the nurses' station area.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review, the facility failed to ensure a resident's choice for a representative was honored. This applies to 1 of 16 residents (R3) reviewed for residents' rights. The findings include:R3 was readmitted to facility on June 02, 2025, with multiple diagnoses including neuroleptic Parkinson's, selective mutism, major depressive disorder, need for assistance with personal care, weakness, muscle wasting, tremors, catatonic disorders and anxiety.R3's face sheet showed a general note section where it was documented that V16 (Family member) was R3's power of attorney (POA). Writer had spoken with V16, and facility was preparing to accept R3 into the facility.R3's progress notes showed the last communication with V16 was on November 21, 2025.R3's hospital discharge instructions dated and uploaded on March 25, 2025, showed V16 is R3's legal guardian and substitute decision maker.On April 07, 2026, at 2:48PM, V16 said that they had tried consistently for months to get in touch with the facility's care team to discuss R3's condition and had not received any response. V16 said they called twice in January, three times in February, and three times in March and had finally received a return call on Monday April 06, 2026. V16 said they do not live close to the facility and relied on the care team to provide information regarding R3's care, especially since R3 is mute and unable to advocate for themself. V16 said there are court documents to show that V16 is R3's guardian and does not understand why it has taken so long for a return call. V16 said they are concerned about the lack of communication for other residents and family members.On April 08, 2026, R3's guardianship paperwork was entered into the electronic medical record (EMR) by V6 (Social Services) and V16's contact information was added under contacts on R3's face sheet.On April 08, 2026, at 11:03AM V6 reviewed R3's face sheet and said they did not enter the general note that stated V16 was R3's POA and said that perhaps nursing had entered that information.On April 10, 2026, at 1:30PM, V2 (Interim Director of Nursing) reviewed R3's chart and said that they did not write the general note on R3's face sheet that said that V16 was R3's POA. V2 said they had just learned that V16 wanted to speak with V2 on Friday April 03, 2026. V2 said they were off on Monday April 06, 2026, so they called V16 on Tuesday April 08, 2026, apologized for the communication delay and reviewed all medical diagnoses and medication regimen. V2 said that they previously only looked at the contact list in R3's EMR to determine if R3 had a POA and had not contacted V16 because R3 had not had a change in condition and there was no information listed under the contact list. V2 said they had never reviewed the general notes section on R3's face sheet and that they should have looked in other areas of the R3's EMR for additional information.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care for residents who require assistance with care.This applies to 2 of 10 residents (R1, R6,) reviewed for ADLs.The findings include:1. R1 was admitted to the facility on [DATE]. R1 has multiple diagnoses including spinal stenosis, congestive heart failure, type II diabetes, cardiomyopathy, hypercholesteremia, atrial fibrillation, anxiety, hyperlipidemia, morbid obesity, functional quadriplegia, low back pain, edema, depression, restless leg syndrome, and need for assistance with personal use.R1's minimum data set (MDS) dated [DATE], showed R1 is cognitively intact and requires a wheelchair for mobility. R1 requires maximal assistance from staff with toileting, showers, dressing, transfers, standing and personal hygiene.R1's current physician's orders showed an order for oxygen at bedtime related to acute embolism and thrombosis.R1's current care plan showed that R1 is incontinent of bladder and that staff should check and change R1 according to facility protocol and administer appropriate cleansing and peri-care after each incontinent episode. Staff should provide R1 with opportunities to go to the toilet before and after meals, activities, laying down for naps and at bedtime.On April 07, 2026, at 11:56 AM, R1 was observed in their room sitting in a wheelchair. R1's hair was greasy, and shirt was soiled. R1 stated that R1 was in the same clothes that they went to bed in. R1 said the staff did not assist them in getting dressed for bed the night before. R1 said that the staff does not place the adult brief on correctly or use the correct size which causes them to soil clothing and bed linen often. R1 said that there are times when staff will not change the adult brief and R1 then has to struggle to change the brief alone. R1 said that they do not like to do this for fear that they may fall but the alternative would be that they remained lying in urine for endless amounts of time. R1 said that overnight CNAs (Certified Nurses Assistants) had not provided them with a new adult brief the night before and they went to bed with just clothes on from earlier in the day and no brief. R1 said they went all night long with wet sheets that had not been changed and that it took staff a long time to empty urinals as well. R1 said staff do not help push residents in wheelchairs, R1 said they have to wheel from their room all the way down to the therapy gym on the other side of the building alone. R1 said that by the time they get to the gym, they are already tired from the long haul down. When they are too tired, they may refuse therapy or care, and it is counted against them. R1 said that when they asked for assistance, staff said that R1 was supposed to wheel the chair on their own. R1 said that they have only received a shower once since entering the facility. R1 requested a bed bath on one occasion and staff handed R1 a bucket with water and a towel and told them that they had to do the bed bath themself. R1 said that staff do not like to assist with showers, so they say that R1 has refused. R1 said that they have not refused showers because R1 does not like to feel dirty and knows that the help is needed. R1 said that it is not easy for R1 to reach certain areas due to size and back pain and R1 therefore requires assistance. R1 said that they often attempt to put themselves into bed because some of the staff do not help.On April 08, 2026, at 2:47 PM, R1 was sitting on the edge of the bed in R1's room. R1 said that R1 transferred to the bed alone because staff would not assist. On April 09, 2026, at 1:19 PM, R1 was wheeling themselves from their room to go out for a smoke break. R1 was visibly tired and moving about slowly. R1's room is not far from the exit door to the smoking area. A resident walking behind R1 on the way to the smoking area asked V5 (Activities Director) to assist R1 due to R1 struggling to get down the hall. V5 was near the door leading to the smoke break area when they reluctantly walked towards R1 to help. V5 said to R1 You know we encourage you all to do these things on your own. On April 10, 2026, at 9:34 AM V11 (Physical Therapy Assistant) said that they are familiar with R1 and work with R1 for physical therapy. V11 said that R1 is required to wheel down alone to the therapy gym as a part of R1's therapy, however if R1 is tired and short of breath then staff should assist. V11 said that they have not checked R1's oxygen saturation when R1 enters the gym and was unaware that R1 utilizes (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen therapy at bedtime. V11 said that R1 should be transferred using a mechanical lift and should not be encouraged to transfer alone.On April 09, 2026, at 12:05 PM V10 (CNA) said that R1 will sometimes refuse care if R1 is in a bad mood but will often apologize and cooperate once given time to settle down.On April 10, 2026, at 10:00AM V2 (Interim DON) asked R1 if they had received a bed bath the evening before. R1 said that they had not received a bed bath and were unsure of what happened the evening before. 2. R6 was admitted to the facility on [DATE]. R6 has multiple diagnoses including cerebral palsy, paraplegia, epilepsy, asthma, morbid severe obesity, type II diabetes, schizoaffective disorder, anxiety, anemia, schizophrenia, depressive disorder, psychosis, suicidal ideations and hypertension.R6's MDS dated [DATE], showed R6 is cognitively intact and requires a wheelchair for mobility. R6 requires touching assistance for eating, is dependent on staff for toileting, transfers, showers, and dressing and requires maximal assistance for personal hygiene.R6's current care plan showed R6 is incontinent with bladder and staff should administer appropriate cleansing and perineal care after each incontinent episode. Staff should provide R6 with the opportunity to use the toilet before and after meals, activities, and laying down for naps and bedtime. Staff should provide physical assistance with toileting needs and staff should remind R6 to use the toilet every two hours.On April 08, 2026, at 3:05 PM, R6 was leaning towards the right side of the wheelchair. R6 said that they were not comfortable in the way in which they were situated in the chair but said the staff did not help to straighten them out. R6 said that on the evening shift prior, they had to wait for the adult brief to be changed from 8:30 PM until 9:15 PM because R6's assigned CNA was on break and they were told that they had to wait until the CNA returned to be assisted. R6 said that they are on a list for the overnight CNAs to get them up and ready for the day. R6 said that a lot of the staff do not like to do this and often tell R6 that they are short staffed to avoid getting them up for the day. R6 is then left alone to attempt to do things by themself or wait for the next shift. R6 said that R1 was their previous roommate. R6 had recently moved to a different room because they were not getting along. R6 said that they watched staff treat R1 terribly. R6 said that R1 fell from the bed twice and staff told R1 that R1 was falling to get a new bed. R6 said that they also heard staff tell R1 that R1 needed to get in the wheelchair on their own and that R6 did not need a mechanical lift to do so.On April 09, 2026, R6 was pushed in the wheelchair by another resident at 12:30 PM, 1:19 PM, and 2:30 PM. R6 was slumped over to the right side of the wheelchair as several staff members walked by.On April 10, 2026, R6 was pushed in the wheelchair by another resident at 10:00 AM and 1:30 PM. R6 was slumped over to the right side of the wheelchair.On April 10, 2026, at 1:30PM V2 said that showers are given twice a week and as needed. V2 said that garbage should be emptied frequently throughout the shift and immediately when soiled items are placed in the receptacle. V2 said urinals should not be left at the resident's bedside and should be emptied when filled or as soon as possible. Urinals should not be left for hours at the bedside. V2 said that staff should assist residents in need regardless of level of dependance. Staff are to assess resident needs day by day, and shift by shift to determine the level of assistance needed at that time. V2 said that residents are to be checked and changed promptly.The facilities Activities of Daily Living policy showed: Residents are given routine care and night care by a CNA or a nurse to promote hygiene, provide comfort, and provide a homelike environment. ADL care is provided throughout the day, evening, and night as care planned and/ or as needed. ADL care is coordinated between the resident and the care givers with emphasis on resident preference as much as possible. ADL care of the resident includes assisting in personal care such as bathing, showering, dressing, eating, hair care, nail care, oral care, appropriate skin care as well as encouraging participation in physical, social and recreational activities, and assisting with movement and ambulation and range of motion as indicated and care planned.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered within acceptable time parameters. This applies to 4 of 7 residents (R1, R11, R12, R13,) reviewed for medication administration. The findings include:.1.R1 was admitted to the facility on [DATE]. R1 has multiple diagnoses including spinal stenosis, congestive heart failure, type II diabetes, cardiomyopathy, hypercholesteremia, atrial fibrillation, anxiety, hyperlipidemia, morbid obesity, functional quadriplegia, low back pain, edema, depression, restless leg syndrome, and need for assistance with personal use.R1's April 2026 medication administration record (MAR) showed R1 has an order for Acetaminophen 500 milligrams (mg): give two tablets by mouth every four hours as needed for pain, Oxycodone 5-325mg: give one tablet by mouth every six hours as needed for a pain level of 7 or above.On April 07, 2026, at 11:56 AM, R1 said that medications often come late. R1 said that when R1 asks for pain medications, R1 is given several different responses. R1 said that some nurses will tell R1 that R1 can only receive pain medications every eight hours while others will inform R1 that they have to wait twenty-four hours. R1 said that they have bad back pain that is not taken seriously. 2. R11 was admitted to the facility on [DATE]. R11 has multiple diagnoses including hemiplegia and hemiparesis, weakness, unsteadiness on feet, anemia, hypertension, psychoactive substance abuse, cerebrovascular disease, hyperlipidemia, type II diabetes, and abnormal gait and mobility.R11's April 2026 (MAR) showed an order for Novolog injection solution 100 units per milliliter (ml) with sliding scale to be given at 0600, 1100, and 1600 daily before meals.3. R12 was admitted to the facility on [DATE]. R12 has multiple diagnoses including hemiplegia, hemiparesis, absence of left leg, atrial fibrillation, type II diabetes, peripheral vascular disease, hypertension, falls, and agitation.R12's April 2026 MAR showed an order for Insulin Lispro injection Solution 100 unit/ml with sliding scale to be given at 0700, 1100, and 1600 daily before meals.4. R13 was admitted to the facility on [DATE]. R13 has multiple diagnoses including hemiplegia, hemiparesis, viral hepatitis b, difficulty walking, type II diabetes, lack of coordination, muscle wasting, chronic kidney disease, heart disease, morbid severe obesity, congestive heart failure, hypertension, and hypothyroidism.R13's April 2026 MAR showed an order for Insulin Lispro 100 unit/ml solution with a sliding scale to be administered at 0600, 1100, and 1600 daily and an order for NovoLog flex pen 100 unit/ml solution pen injector with orders to inject eight units subcutaneously three times daily at 0600, 1100, and 1600 daily before meals.On April 07, 2026, at 12:53 PM, V13 (Agency RN) was administering medications. V13's electronic medication administration record (EMAR) for the unit was open and R11, R12, and R13's EMARs were highlighted in red for the 1100 medication pass. V13 said that when the EMAR is highlighted in red it means that the medication is past due and was not given. V13 said blood glucose checks and sliding scale insulin are performed prior to meals. V13 said they believe lunch is around 12:00 PM.On April 09, 2026, at 10:20 AM, V9 (RN) was passing medications. V9's EMAR showed residents' profile highlighted in red. V9 said that a profile highlighted in red meant that medications had not been administered. V9 said the medications were administered but had not been signed out. V9 said that medication is to be signed out when administered to residents. V9 said that it is not possible to administer medications in the allotted time at the facility or to sign medications out as given because there is always a lot going on.On April 09, 2026, at 10:15 AM V23 (LPN) was standing at the medication cart passing medications. V23 said that residents who were highlighted in red had not received their medications yet and that red meant that the medications were past due.On April 10, 2023, at 1:30 PM V2 (Interim DON) said that the color code system in the EMAR tells when medications are due for administration. V2 said that a profile highlighted in green means the medications have been administered, yellow means the medication is due for administration, red means the medication is past due, and white means the medication is not due yet. V2 said medications should be signed off as administered by staff and that medications can be administered (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one hour before and one hour after the scheduled time for example a medication scheduled for 0800 can be given between 0700-0900. A red profile means the medications were not administered during the time frame of one hour before or one hour after administration time. The facility's Drug Administration-General Guideline Policy showed that medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. The procedure showed 8.) medications are administered within sixty minutes of scheduled time, except before and after meal orders, which are administered precisely as ordered. Unless otherwise specified by physician, routine medications are administered according to the established administration schedule for the facility.

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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 and interview, the facility failed to perform hand hygiene before and after providing incontinence care. This applies to 1 (R5) of 4 residents reviewed for infection control. The findings include: R5 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction, metabolic encephalopathy, cognitive social or emotional deficit, cerebral infarction, epilepsy, chronic kidney disease, bipolar disease, hypertension and bradycardia.R5's minimum data set (MDS) dated [DATE], showed that R5 required maximal assistance from staff for all activities of daily living (ADL) including toileting. On April 10, 2026, at 11:18 AM, R5 was sitting in a wheelchair near the nurses' station. V26, certified nurse assistant (CNA), wheeled R5 into the bedroom to perform incontinence care. V26 applied gloves without performing hand hygiene. V25 (CNA) entered R5's room donning gloves to assist with care. R5 was placed on the bed and R5's clothing was removed. R5's adult brief had a moderate amount of soft feces. V26 cleansed the area and removed R5's soiled brief. V26 removed soiled brief, removed soiled gloves and sanitized hands before donning new gloves. V25 assisted V26 with applying a new brief, pulling up trousers and placing R5 back into the wheelchair. V25 removed and emptied trash while V26 removed gloves and escorted R5 back to the nurse's station. V25 placed trash and soiled gloves into a larger receptacle. V25 and V26 did not perform hand hygiene after removing gloves, following incontinence care.On April 10, 2026, V2 (Interim Director of Nursing) said that staff should always perform hand hygiene before care, in between patients, and after care. Hand hygiene should also be performed during dining services. V2 said that staff should be sure to wash hands prior to the start of care and before leaving the residents' room.The facility's Handwashing/Hand Hygiene Policy showed the facility considers hand hygiene the primary means to prevent the spread of infection. 7. Use of alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a.) before and after direct contact with residents e.) before donning sterile gloves l.) after removing gloves. 9. The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.