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Form Approved OMB
No. 0938-0391

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	11/15/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview, and record review the facility failed to obtain physician orders for residents to have medications at the bedside and failed to complete self-administration of medication assessments. This applies to 3 of 3 residents (R18, R38, R58) reviewed for medications in a sample of 18. The findings include: 1. On 11/13/24 at 11:34 AM, R58 was observed sleeping in her bed. Her Fluticasone Propionate nasal spray 50 MG (Milligrams) was inside a box labeled with her name on the dresser that belonged to her roommate (R18) behind her curtain. Surveyor asked (R18) if it was hers and if she ever used it. R18 just stared at Surveyor and smiled. V6 (RN-Registered Nurse/Wound Nurse) who was in the room stated that R18 was nonverbal. On 11/13/24 at 2:18 PM, V2 (DON-Director of Nursing) said, I currently don't have any residents that can self-administer any medications. Any meds (medications) at the bedside need an order from the doctor. The nurse also must do a self-administration of medication assessment. It's important because we need the resident to be competent and that they understand the dosage. On 11/14/24 at 10:42 AM, R58's Fluticasone Propionate nasal spray was still on top of R18's (roommate) dresser. Surveyor asked R58 if this was hers. She said, Yes and I've been looking for it. She said it's always kept in her room. R58 said, No one taught me how to use it. I know how to do it. I use it at bedtime. R58 then put the box of Fluticasone Propionate in her basin which was on her bedside table. R58's face sheet shows diagnoses of need for assistance with personal care and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R58's MDS (Minimum Data Set) dated 10/18/24 shows she is cognitively intact. R58's POS (Physician Order Sheet) shows an order for Fluticasone Propionate Nasal Suspension 50 MCG (Micrograms)/ACT-1 spray in both nostrils two times a day for antihistamine. There was no order for the nasal spray to be at the bed side upon review of her POS. There was no self-administration of medication assessment uploaded into her electronic medical record. There was no care plan stating she can self-administer. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's face sheet shows diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, aphasia following cerebral infarction, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder recurrent, severe with psychotic symptoms, bipolar disorder, and anxiety disorder. Review of her POS shows no order for Fluticasone Propionate nasal spray. R18's MDS dated [DATE] shows a blank score for her mental status. R18's care plans do not state she can self-administer any medications. Facility's policy titled Self-Administration of Medications by Residents (Undated) shows: 2. If the resident desires to self-administer medications, an assessment is conducted by an interdisciplinary team. This assessment includes the resident's cognitive, physical, and visual ability to carry out this responsibility. 3. An interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment as follows: b. The resident is instructed in the use of the package, purpose of the medication, reading of the label, scheduling of medication doses and side effects. D. The resident is asked to demonstrate the removal of the medication from the package and, in the case of nonsolid dosage forms, e.g. inhaler, to verbalize the steps above involved in administration. e. If bedside storage is to be used, the resident is asked to complete a bedside record indicating the administration of the medication. 4. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted. A. The storage does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. B. The storage method prevents access by other residents. 6. Once the order has been obtained, the procedure is explained to the resident. 48526 2. On 11/12/24 at 11:59 AM, R38 was not in his room. R38 had two white pills on the bedside table next to a medication cup. On 11/12/24 at 12:14 PM V2 (Director of Nursing) went to R38's room with the surveyor. The two white pills remained on the bedside table. R38's face sheet showed multiple diagnoses which included cerebral infarction, metabolic encephalopathy, malignant neoplasm of the colon, need for assistance with personal care, cocaine abuse, weakness. R38's MDS dated [DATE] showed R38 was cognitively intact. R38 had no self-administration of medication assessment in the electronic medical record. R38's POS for November 2024 showed no orders for medications to be left at the bedside. R38 did not have a care plan for self-administering medications.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on interview and record review the facility failed to provide a resident and/or his family/POA (Power of Attorney) the reason of transfer to the hospital in writing. The facility also failed to notify the ombudsman of the transfer.This applies to 4 of 4 residents (R7, R26, R38, R74) reviewed for discharge in a sample of 18. The findings include: 1. On 11/13/24 at 2:27 PM, V2 (DON-Director of Nursing) stated, We don't notify the ombudsman about the transfer to the hospital. We don't get the ombudsman involved in the discharge or transfer of a resident. We only notify the ombudsman if the resident is non-compliant with something, or we can't reach an agreement with the resident. We didn't give a written notice to (R74) and his POA at the time of discharge to the hospital or afterwards. We notified the POA by phone. If we can't reach the POA, then social services emails or gives them a written notice. There's nothing uploaded in the resident's chart regarding the written notice of discharge to the hospital or notification that the ombudsman was notified. R74's face sheet shows an admitted [DATE] to the facility. R74's progress notes document the following: On 9/19/24 at 10:30 AM, (R74) observed on floor positioned on buttock with against door in bedroom. No injuries, no skin alterations. Resident noted being verbally aggressive towards staff. MD (Medical Doctor) notified. Received order to transfer to (Hospital) for CT (Computerized Tomography) scan and psych evaluation. Order carried out. DON (Director of Nursing) and family POA made aware. On 9/19/24 at 10:45 AM, Paramedics have arrived to transport resident to (Hospital) ER (emergency room) via stretcher. Bed hold policy in place. On 9/20/24 at 9:54 AM, (R74) admitted to hospital with a diagnosis of aggressive behavior. On 10/11/24 at 12:10 PM, (R74) readmitted to facility A+O x 1-2 with confusion in stable condition. All safety precautions in place. MD made aware of all orders verified. Review of R74's electronic medical record shows nothing was uploaded regarding the discharge notice to the resident/POA. Facility's policy titled Discharge/Transfer of the Resident (1/1/2020) shows: Transfer: 3. Explain transfer and reason to the resident and/or representative and give copy of signed transfer or discharge notice to the resident and/or representative or persons (s) responsible for care. Note: If emergency transfer, Transfer or Discharge Notice form may be completed later, but as soon as possible. 48526 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R7's face sheet showed R7 was admitted to the facility on [DATE]. R7 had multiple diagnoses which included acute respiratory failure with hypoxia, weakness, atrial fibrillation, diabetes, dementia, muscle wasting, and anxiety disorder. R7's MDS (MDS/Minimum Data Set) dated 09/20/24 showed R7 had moderate cognitive impairment. R7's progress notes showed the following: On 08/27/24 at 8:06 PM while doing rounds, (R7) observed lying on floor in front of his toilet. Skin alteration to rt eye. Ice placed on rt eye. Tylenol given for pain. Resident transferred into bed. First aid rendered. BP 74/62, O2 79%, resp 20, pulse, 90 BS 134. MD notified with new orders to send to (Hospital), DON notified. Family attempted to be reached x3. Unable to leave message. Will continue to try to reach family. On 08/28/24 at 6:31 AM called into (Hospital) for update. (R7) being admitted d/t low hemoglobin. On 09/24/24 at 11:00 AM writer observed (R7) face to be drooping to left side, puffy face, swelling to right hand/arm. Vitals 143/68, 97.6, 92, 18, 81% r/a, applied O2 n/c @ 2L, SPO2 now at 99%. MD notified received order to transfer out to hospital, order carried out. 911 called to transport (R7) to hospital. Family, DON and ADON made aware. On 09/24/24 at 11:25 AM Paramedics have arrived to transport (R7) to (Hospital) via stretcher. On 09/25/24 (R7) admitted to (Hospital). Admitting dx DVT to rt arm. On 09/29/24 at 8:30 AM While doing rounds (R7) observed with SOB, low O2, and diaphoretic. Vitals taken. Increased O2. MD notified. Per MD ok to send to (Hospital) for eval and treat. On 09/29/24 at 3:24 PM Called ER for update. (R7) being admitted for SOB and hypoxia. R7's electronic medical record showed no uploaded information regarding the discharge letter to R7 or R7's representative. The facility was unable to provide information regarding the discharge or notification of the ombudsman of the discharge. 3. R26's face sheet showed R26 was admitted to the facility on [DATE]. R26 had multiple diagnoses which included multiple fractures of ribs, muscle wasting and atrophy, schizoaffective disorder, major depressive disorder, epilepsy, post-traumatic stress disorder, and suicidal ideations. R26's MDS dated [DATE] showed R26 was cognitively intact. R26's progress notes showed the following: On 05/08/24 at 9:00 PM 911 arrived to the facility stating that R26 had just placed a call to the suicide hotline. Prior to R26 placing a call she was observed resting in her bed. When R26 was asked by the writer and the police officers what was wrong, R26 stated that she was depressed and did not want to talk about it. Ambulance arrived to facility and transported to (Hospital). MD made aware. On 05/09/24 at 3:11 AM Writer placed a call to the hospital for an update on R26 status. R26 got admitted to (Hospital). Dx depression. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/22/24 at 6:15 PM R26 expressing suicidal ideations d/t not wanting to be at the facility anymore. R26 stated she wants to die and that she has a plan. She stated she could take a lot of pills to die. Contacted NP and orders are to send out to be further evaluated. R26 placed on 1:1 until ambulance arrived. R26 is her own responsible party. On 07/22/24 at 7:11 PM ambulance arrived to transport R26 to (Hospital) x 3 EMT via stretcher. R26 is her own responsible party. Report from off going nurse states all parties were informed. On 07/23/24 at 5:12 AM Call placed to (Hospital) to get update on R26. Shift change is taking place. Advised to call back. Will endorse to oncoming nurse. R26's electronic medical record showed no uploaded information regarding the discharge letter to R26 or R26's representative. The facility was unable to provide information regarding the discharge or notification of the ombudsman of the discharge. 4. R38's face sheet showed R38 was admitted to the facility on [DATE]. R38 had multiple diagnoses which included cerebral infarction due to embolism of right cerebellar artery, metabolic encephalopathy, asthma, acute respiratory failure with hypoxia, malignant neoplasm of the colon, need for assistance with personal care, and cocaine abuse. R38's MDS dated [DATE] showed R38 was cognitively intact. R38's progress notes showed the following: On 08/24/24 at 6:35 PM Altered mental status noted during rounding. V/S 98/64, 86, 16, 99.9, 83% on room air (O2 applied), blood glucose 257, not responding to painful stimuli. MD was notified and said to send R38 to the ER. 911 called and arrived shortly. R38's emergency contacts were called. Both of their phone numbers were disconnected. The DON was contacted. On 08/24/24 at 10:54 PM per (Nurse) from (Hospital) R38 was admitted for Pneumonia, Hypoxia, UTI, and Acute Kidney Injury. On 09/16/24 at 6:28 PM R38 observed in bed not easily aroused. Sternum rub applied no response. Vitals taken B/P 119/69, P 89, T98, R16, O2 90% room air. Blood sugar 161. Elevated head of bed applied 3L O2 NC O2 stats increased to 95%. Attempted to arouse, unable. Placed call to 911. MD, ADON notified. Attempt to reach family no answer. On 09/16/24 at 6:35 PM EMT arrived to facility. Transferred resident onto gurney. Exiting building to (Hospital) ER. Report called in to charge nurse. MD/DON aware. On 09/17/24 at 6:48 AM Called (Hospital) to get report. Shift change happening. (Hospital) will call back later. On 09/19/24 at 12:14 AM Spoke with RN at (Hospital). R38 admitted to IMCU with a dx of Acute Renal Failure. R38 is expected to be discharged back to the facility within the next 48 hours. On 09/25/24 at 12:15 PM R38 noted with change in condition. R38 unable to arouse. Checked vitals, B/P 83/53, P 74, R16, T97.9, O2 90% room air. Call placed to MD orders to send out to (Hospital) for further evaluation and treatment. Call placed to 911 for transport. POA notified. On 09/25/24 at 12:28 PM EMT arrived to facility, transferred onto gurney by EMT. Exiting the building. On 09/26/24 at 6:58 AM (Hospital) called. R38 admitted for observation with dx of generalized weakness & altered mental status. Med list faxed. R38's electronic medical record showed no uploaded information regarding the discharge letter to R38 or R38's representative. The facility was unable to provide information regarding the discharge or notification of the ombudsman of the discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 3:22 PM, V1 (Administrator) stated the ombudsman should be notified each time a resident is admitted to the hospital. I was not aware that we were supposed to send a written copy as to why a discharge or transfer to the hospital was occurring to the residents/representative. The residents did not receive written documentation notifying of the reason why they were transferring to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on interview and record review the facility failed to provide in writing to residents and their families/POA (Power of Attorney) regarding bed hold and return at the time of discharge to the hospital. This applies to 4 of 4 residents (R7, R26, R38, R74)) reviewed for discharge in a sample of 18. The findings include: 1. On 11/13/24 at 2:27 PM, V2 (DON-Director of Nursing) stated, We hold the bed for 10 days. That's guaranteed to the patient. We don't typically keep a copy of the bed hold notice. R74's face sheet shows an admitted [DATE] to the facility. R74's progress notes document the following: On 9/19/24 at 10:30 AM, (R74) observed on floor positioned on buttock with against door in bedroom. No injuries no skin alterations. Resident noted being verbally aggressive towards staff. MD (Medical Doctor) notified. Received order to transfer to (Hospital) for CT (Computerized Tomography) scan and psych evaluation. Order carried out. DON (Director of Nursing) and family POA made aware. On 9/20/24 at 9:54 AM, (R74) admitted to hospital with a diagnosis of aggressive behavior. Review of R74's electronic medical record shows nothing was uploaded regarding the bed hold provided to the resident/POA. The facility was unable to show proof the bed-hold policy was provided to R74. 48526 2. R7's face sheet showed R7 was admitted to the facility on [DATE]. R7 had multiple diagnoses which included acute respiratory failure with hypoxia, weakness, atrial fibrillation, diabetes, dementia, muscle wasting, and anxiety disorder. R7's MDS (Minimum Data Set) dated 09/20/24 showed R7 had moderate cognitive impairment. R7's progress notes showed the following: On 08/27/24 at 8:06 PM while doing rounds, (R7) observed lying on floor in front of his toilet. Skin alteration to rt eye. Ice placed on rt eye. Tylenol given for pain. Resident transferred into bed. First aid rendered. BP 74/62, O2 79%, resp 20, pulse, 90 BS 134. MD notified with new orders to send to (Hospital), DON notified. Family attempted to be reached x3. Unable to leave message. Will continue to try to reach family. On 08/28/24 at 6:31 AM called into (Hospital) for update. (R7) being admitted d/t low hemoglobin. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review, the facility failed to change PICC (Peripherally Inserted Central Catheter) dressings.This applies to 1 of 7 residents (R75) reviewed for infection control in a sample of 18. Findings include: R75's face sheet showed R75 admitted to the facility on [DATE] with diagnoses that includes cellulitis of the right lower limb, diabetes mellitus, and cutaneous abscess of the foot. R75's MDS (Minimum Data Set) dated 10/29/24 shows she is cognitively intact. On 11/12/24 at 1:01 PM, R75 showed the surveyor the single lumen PICC line in her right upper arm. The PICC had a border gauze dressing in place that had drainage in the center of it. R75 stated the dressing had been in place 4 to 5 days and she had changed it herself. R75 stated the staff did not do the dressing changes on her PICC line. On 11/14/24 at 1:20 PM, R75 stated the dressing on her PICC line had not been changed. R75 showed the surveyor her PICC line had the same stained border gauze dressing, with more soiling and rolled on the sides, exposing the PICC insertion site. On 11/14/24 at 1:41 PM, V3 ADON (Assistant Director of Nursing) stated PICC line dressings are changed every seven days and as needed when a transparent dressing is in place. V3 was unsure the frequency of PICC line dressing changes if a border gauze was in place. On 11/14/24 at 1:51 PM, V2 DON (Director of Nursing) PICC lines and Central line dressings are done every seven days and as needed if a transparent dressing is in place. A gauze type dressing should be changed daily. The gauze has an increased risk of infection. On 11/14/24 at 5:51 PM, V3 ADON stated there was no documentation for R75's PICC dressing changes in her electronic medical record. R75's physician orders document change transparent dressing on admission, then weekly and as needed thereafter. Monitor site every shift for signs / symptoms of infection and or infiltration. R75's current care plan for the PICC line includes monitoring for signs and symptoms of infection. The facility policy Dressing Change, Midline Catheter dated April 2011 states gauze dressings are changed: 24 hours post insertion or upon admission, every 48 hours or if the integrity of the dressing has been compromised (wet loose or soiled). Assessment of venous access site is performed: during dressing changes and at least once every shift when not in use.

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 11/15/2024
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46003 Based on observation, interview and record review the facility failed to maintain the kitchen facility in a manner to prevent foodborne illness.This applies to 74 residents in the facility receiving dietary services. Findings include: On 11/14/24 4:36 PM, V2 DON (Director of Nursing) stated 74 residents were served from dietary services on 11/12/24. On 11/12/24 at 10:45 AM, the dry storage contained: A large bin of breadcrumbs with use by date of 7/28/24. A large bin of oatmeal with use by date of 11/9/24. A large bin of rice with use by date of 10/30/24. A large bin of flour with use by date of 9/18/24. A large bin of thickener with use by date of 7/9/24. A clear plastic bag with dry penne pasta open to air. Two clear plastic bags containing dry fettuccini pasta open to air. Dented cans in rotation for use: Diced beats 6lb (pounds) 8 oz (ounces). Diced carrots 6lb 9 oz. Three cans of diced potatoes 6lb 6oz. Two cans of chunk tuna 4.16lb. The facility policy Storge of Dry Foods / Supplies dated 9/18/23 states dry goods will be handled and stored to maintain the integrity of the packaging until the item is ready to use. Dented cans will be stored separately with a dented cans sign and marked for return or disposal. On 11/12/24 at 10:58 AM, the milk cooler had a sour/spoiled odor. The facility policy Storage of Refrigerated / Frozen foods dated 4/26/2024 states refrigeration units are routinely cleaned and free from garbage and other waste. (continued on next page)

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 11/15/2024
NAME OF PROVIDER OR SUPPLIER Momence Meadows Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/12/24 at 11:00 AM, the walk-in cooler contained: Corn in a clear plastic bag open to air. Pancakes in a clear plastic bag open to air. Breakfast sausage patties in a clear plastic bag open to air. On 11/12/24 at 11:03 AM, the walk-in cooler contained: Yellow cheese slices partially wrapped in plastic with the exposed cheese hardened and open to air. Bologna open to air without an open on or use by date. A large bag of shredded yellow cheese open to air and falling out of the bag. Large unsliced turkey meat wrapped in plastic stored above diced potatoes. Plastic storage container of peeled boiled eggs with use by date of 11/9/24. A 10lb box of hot dogs open to air dated 11/6/24. Six bags of raw liquid eggs in a plastic container with use by date of 11/9/24. The facility policy Receiving and Handling dated 4/2017 states All foods are wrapped in moisture proof wrapping or placed in suitable containers to prevent freezer burn. Items are labeled and dated. Meats, fish, and poultry will be stored on lower shelves below, fruits, vegetables or other ready to eat food to prevent contamination. Food items will be arranged so that older items will be used first. Expiration dates will be monitored. On 11/12/24 at 11:14 AM, an oscillating fan located in the dish area was covered with dust and grease. On 11/12/24 at 11:20 AM, the kitchen contained: A storage bin containing flakes of corn cereal with a use by date of 9/25/24. A storage bin containing crisped rice cereal with a use by date of 9/25/24. A storage bin containing frosted flakes of corn cereal with a use by date of 9/25/24. On 11/13/24 at 03:59 PM, V5 Dietary Manager stated we do not have a separate log for documenting the sanitizer concentration for the red sanitizing buckets. V5 stated dented cans can spoil or become contaminated and should be sent back to the distributor. V5 stated it's important to have the correct date of when the food came in, when it was opened and use by, so we aren't serving outdated or spoiled food items, and the food items should be properly wrapped / stored to prevent contamination and to make sure the food quality remains fresh. V5 stated the turkey should not have been stored over the potatoes, you don't want juice from the turkey getting in the potatoes and contaminating them. (continued on next page)

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 11/15/2024

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V5 stated the cereal wouldn't spoil it would just be stale. I don't have a reference for how long dry goods are good for. It should have been dated with the original expiration from the packaging or the delivery date. The pasta should be labeled dated and sealed. The policy Sanitizing Buckets dated 9/22/23 states sanitizer concentration will be checked using a test kit. Concentration will be documented on the sanitizer solution log.