

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/11/2025
NAME OF PROVIDER OR SUPPLIER  Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE  4360 Brecksville Rd Richfield, OH 44286	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review and interview, the facility failed to ensure the power of attorney (POA) was notified of a change in condition. This affected one resident (#32) of four residents reviewed for notification of change in condition. The facility census was 51.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #32 revealed an admission date of 01/31/25. Diagnoses included but were not limited to metabolic encephalopathy, acute and chronic respiratory failure, obstructive sleep apnea, congestive heart failure, and morbid obesity. Review of the banner bar of Resident #32's electronic medical record revealed special instructions which stated: POA (power of attorney) would like to be notified of any behaviors or concerns.</p> <p>Review of Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] for Resident #32 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #32 was dependent upon staff for ADLs.</p> <p>Review of the nursing progress note dated 04/17/25 timed 10:32 P.M. written by Registered Nurse (RN) #223 revealed upon entering Resident #32's room, Resident #32 was noted to be bleeding puddles of blood from bed onto floor. Emergency Medical Services (EMS) and Nurse Practitioner (NP) were called, and Resident #32 was sent to the hospital. No evidence was recorded that the POA was notified.</p> <p>Review of the nursing progress note dated 04/18/25 timed at 5:37 A.M. written by RN #223 for Resident #32 returned from the hospital and noted the NP was aware. There was no evidence the POA was notified of the resident's return.</p> <p>Review of the nursing progress noted dated 05/20/25 timed at 5:24 P.M. written by Licensed Practical Nurse (LPN) #215 revealed Resident #32 had worsening symptoms like shortness of breath (SOB), being extremely tired and groggy as the shift progressed. The NP was notified of Resident #32's change in condition and NP assessed Resident #32. LPN #215 was notified to have Resident #32 use his continuous positive airway pressure (CPAP) machine (a device used to treat sleep apnea and other breathing disorders. It delivers a constant stream of pressurized air through a mask to keep the airway open and prevent pauses or shallow breaths) which Resident #32 refused. Resident #32 was noted to be sent out to the hospital at approximately 4:00 P.M. for SOB and change in condition. There was no evidence the resident's POA had been notified.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress note dated 05/23/25 written by LPN #204 revealed Resident #32 returned to the facility and the physician and NP were notified. No evidence was found of the POA being notified of the resident's return.</p> <p>Interview on 06/02/25 at 11:24 A.M. with Resident #32 revealed concerns related to his POA not being notified of changes in his condition and when he has gone to the hospital in the past few months.</p> <p>Interview on 06/03/25 at 11:15 A.M. with the Director of Nursing (DON) confirmed Resident #32's chart had special instructions which listed the POA would like to be notified of concerns. The DON confirmed there was no evidence of the POA being notified when Resident #32 went to the hospital on [DATE], returned on 04/18/25, went to the hospital on [DATE], or when he returned on 05/23/25.</p> <p>Review of the policy Change in Condition Monitoring dated 05/01/22 revealed our facility shall promptly notify the resident, his or her attending physician, and family/Power of Attorney (POA)/guardian of changes in the resident's medical status.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165009.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to ensure a safe, clean, homelike environment by ensuring general cleanliness was maintained, water temperatures reached appropriate and homelike temperatures, and blinds, ceiling tiles, walls, and door frames were without the need for repair. This affected all residents residing in the facility. The facility census was 51.</p> <p>Findings include:</p> <p>During the onsite survey an interview on 06/04/25 at 11:07 A.M. with Chief Operating Officer (COO) revealed she was aware of physical environmental concerns that resulted in citations during the previous annual survey. She verified the physical environmental issues currently in the building, including water temperatures not reaching the appropriate and homelike temperatures, and concerns regarding the general repair and cleanliness of the room were ongoing. The COO confirmed the broken blinds, discolored and bulging ceiling tiles, gouges, and missing paint on walls and door frames, furniture in disrepair, and general housekeeping tasks were not completed by the facility's allegation of compliance date of 04/20/25 as planned in the facility's plan of correction.</p> <p>An interview on 06/09/25 at 1:06 P.M. with the Chief Executive Officer (CEO) confirmed the facility's physical environmental needs were not met by the deadline of 04/20/25 as stated in the facility's previous plan of correction.</p> <p>A follow up interview with the Administrator on 06/11/25 at 11:03 A.M. revealed the new Director of Maintenance who was due to begin employment on 06/09/25 fell through. The Administrator reported she is still in need of a new Director of Maintenance and has refreshed the advertisement for the position. The Administrator stated she had been working with the CEO to develop a revised corrective action plan. The Administrator reported the CEO will be bringing in a contractor and the goal was to go room-to-room to identify the environmental needs of each room.</p> <p>Review of the policy Homelike Environment dated 05/01/22 revealed residents are to be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary environment, adequate lighting, clean bed and bath linens that are in good condition, and pleasant and neutral scents.</p> <p>The following environmental concerns were identified at the time of the onsite investigation:</p> <p>1. Interview on 06/02/25 at 1:47 P.M. with Resident #53 revealed her room was not being cleaned consistently and had not been cleaned for the past five days. Observation at the time of the interview revealed the floor appeared soiled with dried stains.</p> <p>Interview on 06/02/25 at 1:56 P.M. with Resident #49 revealed had previously requested a new mattress due to sinking in the middle several months ago but had not been addressed. Resident #49 also stated the blinds had missing pieces and the bathroom ceiling tile was bulging.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 06/02/25 at 3:48 P.M. with Resident #34 stated sometimes there are no washcloths available for bathing and towels are used.</p> <p>Observation on 06/03/25 from 3:00 P.M. to 4:35 P.M. of a facility tour with the Administrator and Maintenance Director #218 revealed the following concerns</p> <ul style="list-style-type: none"> <li>- Resident #30's room was missing a light bulb above the sink in the resident's room. Saturated paper towels with a strong urine odor were noted on the floor at the entrance to the resident's bathroom near the bed. Resident #30's call light indicator cover was hanging and was not fully attached outside of the resident's room.</li> <li>- Resident #35's room was missing a bottom drawer in front of a three-drawer built-in cabinet. The floor of Resident #35's room was heavily soiled.</li> <li>- The flooring around the 100-hall nurse's station had a trail of various dried brown spots of an unknown substance on the floor.</li> <li>- Resident #49 and Resident #50's shared room had broken blinds covering the window. Ceiling tiles in the bathroom were cracked and bulging. The privacy curtain dividing the room was visibly soiled.</li> <li>- Resident #51's room had two stained ceiling tiles near the entrance door.</li> <li>- The exit door at the end of the 100-hall outside Resident #53's room revealed various loose trash debris including used gloves, napkins, condiment wrappers, lids, etc. outside of the exit door and visibly blowing around the parking lot.</li> <li>- Resident #53's room had multiple holes in the wall and ceiling tiles near the door. There were two stained ceiling tiles, and dried stains on the floor. The toilet paper holder in Resident #53's bathroom was empty, with two rolls of toilet paper on the back of the toilet and a partially used roll of toilet paper not easily reached on the bathroom counter. An interview at the time of observation with Resident #53 stated it was hard to reach the toilet paper, and she wished staff would replace the toilet paper on the older for her and wished staff would clean her floors.</li> <li>- A used glucometer test strip was on the floor outside the rooms of Residents #49, #50, #51, and #52.</li> <li>- Resident #40's floor was visibly soiled. Resident #40's toilet was visibly soiled with dried brown stains around the whole base of the commode. The bathroom had a strong pervasive odor, and the bathroom light was missing a cover.</li> <li>- The [NAME] shower room had cracked tiles to the floor and edges.</li> <li>- Resident #41's room contained a sink, above which were dirty dishes with the present of gnats. Resident #41's baseboards near the bathroom were loose.</li> <li>- Resident #42's electrical outlet between the bathroom and the bed had visible white rough spackling and dried white powder on the floor below. There were large stains on the ceiling tiles and the bathroom floor and fixtures were visibly soiled.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>- Resident #43 and Resident #44's shared room had a visibly dirty floor with dried brown spots around and behind the toilet. The bathroom had a strong pervasive odor. The bathroom doorframe was visible eroded from a prior leak, and dried stains were visible on the window blinds.</li> <li>- Resident #45's room contained two missing tiles near the sink base and the floor of the room was visibly soiled.</li> <li>- Resident #1 and Resident #2's shared room had two missing light bulbs in the room and no cover over the bathroom light.</li> <li>- Resident #3 and Resident #4's shared room floor was visibly soiled with various debris. The bathroom was wet with what appeared to be a leak.</li> <li>- Resident #5's bathroom had stains splattered on the blinds and walls surrounding the window.</li> <li>- There was a partially missing floor tile on the [NAME] hall entrance to the dining room.</li> <li>- There was missing wood trim pieces above the handrail outside room [ROOM NUMBER] which was vacant at the time of the survey.</li> <li>- Resident #6's room had a soiled privacy curtain. There were bulging ceiling tiles above the sink in Resident #6's room. The bathroom floor had wet, soiled paper towels in a pile on the floor.</li> <li>- Resident #7 had a stained ceiling tile above the bed and the room contained broken window blinds.</li> <li>- Resident #8's room had a hole in the wall next to the bed. There was a stained ceiling tile near the air conditioning unit.</li> <li>- Resident #9's room had peeling paint on the bathroom door, stained and bulging ceiling tiles above the bed, and a missing trim piece near the entrance door to the room.</li> <li>- Resident #10's room had three missing light bulbs, seven stained ceiling tiles, and six missing drawers on the bathroom cabinet. The clock in the room was non-functional. There were no paper towels in the room and the entrance door was missing the mechanism/latch for the door handle.</li> <li>- Resident #11's room had gouges on the wall and a visibly soiled floor.</li> <li>- The dining room floor in the memory care unit was peeling up. The peeling floor had previously been taped down but the tape had worn off and was not secured.</li> <li>- Resident #14 and Resident #15's shared room contained visibly soiled floors to the room. The bathroom contained a visibly soiled toilet seat.</li> <li>- Resident #17's room had a dirty privacy curtain and a bathroom with surfaces which were visibly soiled.</li> <li>- The East shower room had a stained ceiling tile near the vent near the entry door.</li> </ul> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>- Resident #18's room contained various stains on the floor. Resident #18 was missing a drawer in the room vanity.</li> <li>- Resident #19's room had a stained privacy curtain that would not slide on the track. There was a brown stained sheet on the bed. The wall underneath the window had missing paint. There was a broken drawer in the dresser cabinet. The resident's bathroom was visibly soiled and had a strong pervasive odor.</li> <li>- Resident #21's room had a visibly dirty fan with a soiled and sticky floor.</li> <li>- Resident #22's room had a heavily soiled floor.</li> <li>- Resident #25 and Resident #26's room contained no privacy curtain.</li> </ul> <p>The Administrator confirmed the above findings at the time of observation during the facility environmental tour.</p> <p>2. Review of the facility water temperature logs dated 04/21/25, 04/28/25, 05/05/25, 05/12/25, 05/20/25 and 05/27/25 revealed on 04/28/25 the East one shower room was recorded as 103.2 degrees Fahrenheit (F), on 05/12/25 the East two shower rooms were recorded as 103.4 degrees F and on 05/27/25 the East one shower room was recorded as 103.1 degrees F.</p> <p>Observation and interview on 06/02/25 at 12:00 P.M. with the Administrator conducting water temperatures revealed the shared bathroom for Resident #34 and #35's faucet was 103.1 degrees F after running the hot water for a few minutes and the hot water in the East shower room was 100.7 degrees F. The Administrator confirmed the above findings at the time of observation and confirmed the water temperatures did not meet the required minimum of 105 degrees F.</p> <p>Review of the 05/01/22 facility policy called Water Temperature revealed maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. Water temperatures would not be more than 120 degrees.</p> <p>3. An observation on 06/04/25 at 9:15 A.M. with Maintenance Director #218 of the shower rooms revealed the rooms contained no washcloths in the East shower room and approximately 10 washcloths in the [NAME] shower room. Maintenance Director #218 confirmed the lack of washcloths in the shower room.</p> <p>Observation on 06/04/25 at 9:15 A.M. with Maintenance Director #218 of the shower rooms revealed no washcloths in the east shower room and approximately 10 washcloths in the west shower room. Maintenance Director #218 confirmed the above observations.</p> <p>Observation on 06/04/25 at 9:22 A.M. of the laundry area with Maintenance Director #218 and Laundry Staff #229 revealed no washcloths in the clean laundry area. Laundry Staff #229 confirmed staff frequently run out of washcloths and reported more were on order but had not arrived and he was waiting for the dirty washcloths to come back to laundry to wash them for resident use.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00165391 and Complaint Number OH00165087.</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of personnel files, interviews, and review of the nursing job description, the facility failed to ensure nurses providing direct care to residents maintained current cardiopulmonary resuscitation (CPR) certification. This had the potential to affect all 37 residents whose advanced directives were listed as full code (term used to signify all measures which should be taken to resuscitate, including CPR). The facility census was 51.</p> <p>Findings include:</p> <p>Review of the personnel files for three licensed practical nurses (LPNs) and the Director of Nursing (DON) revealed one LPN (LPN #215) had a hire date of [DATE] with proof of CPR certification from [DATE] through [DATE] and from [DATE] through [DATE]. There was no evidence LPN #215 had active CPR certification from [DATE] through [DATE].</p> <p>Interview on [DATE] at 3:30 P.M. with Business Office Manager (BOM) #207 confirmed there was no evidence of active CPR certification for LPN #215 in the personnel file. During the interview, it was revealed that BOM #207 just started the Human Resources position the end of [DATE] and began performing personnel file audits, at which time she notified any staff whose file was noted to have missing necessary items, such as documentation of active CPR certification during their course of employment, and she had received the CPR documentation with the issue date of [DATE].</p> <p>During a follow-up interview on [DATE] at 5:00 P.M., BOM #207 provided proof of ongoing, valid CPR for LPN #223 and LPN #228, whose files previously showed a gap in certification, but confirmed there was no further documentation of CPR certification from the time of the lapsed certification (expired [DATE]) and the new certification (issued [DATE]).</p> <p>Interview on [DATE] at 10:54 A.M. with LPN #215 confirmed there was a gap in her CPR certification and that LPN #215 was not certified in CPR from the end of [DATE] until [DATE].</p> <p>Interview on [DATE] at 11:00 A.M. with the DON confirmed all facility nurses should maintain current CPR certification. A follow-up interview on [DATE] at 12:28 P.M. with the DON confirmed LPN #215 was assigned to work units per facility need and could work on any unit.</p> <p>Review of the job description for Licensed Practical Nurse last updated [DATE] revealed the LPN must be certified in CPR.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165087.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review and interview, the facility failed to ensure weights were obtained upon readmission from the hospital and refusals were consistently documented. This affected one resident (Resident #32) of four residents reviewed for weights. The facility census was 51.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #32 revealed an admission date of 01/31/25. Diagnoses included but were not limited to metabolic encephalopathy, acute and chronic respiratory failure, obstructive sleep apnea, congestive heart failure, and morbid obesity.</p> <p>Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #32 had a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) indicated Resident #32 was dependent upon staff for ADLs.</p> <p>Review of the physician order dated 04/18/25 and discontinued on 05/22/25 for Resident #32 revealed an order for monthly weights every day shift starting on the 18th every month for screening.</p> <p>Review of the most recent weight recorded in the medical record for Resident #32 revealed it was on 04/18/25 with a weight of 536 pounds.</p> <p>Review of Resident #32's census revealed Resident #32 went to the hospital on [DATE] and returned on 05/23/25.</p> <p>Review of the 05/23/25 nursing admission assessment with care plan revealed under section four: dietary/nutritional status section revealed the most recent weight was 536 pounds from 04/18/25. No indication was recorded of any resident refusal.</p> <p>Review of the nursing progress notes dated 05/23/25 for readmission revealed no documentation of weight refusal for Resident #32.</p> <p>Review of the physician orders following hospitalization on 05/20/25 and readmission on [DATE] revealed no physician orders for weight monitoring frequency.</p> <p>Interview on 06/03/25 at 11:15 A.M. with the DON confirmed there was no readmission weight was obtained nor was a refusal documented for Resident #32 upon readmission from the hospital on [DATE] as required.</p> <p>Review of the policy Weight Management dated 05/01/22 revealed the nursing assistant will weigh residents within 24 hours of admission to the facility, then weekly for four weeks and then monthly thereafter. Resident's weight information is recorded and trended in the medical record by the unit manager or charge nurse.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165009.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and review of the facility menus, the facility failed to serve palatable meals at appetizing temperatures for residents' meals. This had the potential to affect all 51 residents residing in the facility. The facility indicated all residents received meals from the kitchen. The facility census was 51.</p> <p>Findings include:</p> <p>Review of the breakfast menu for 06/03/25 revealed the planned meal included a cheese omelet, two breakfast sausage links, cold or hot cereal, assorted juices, and milk of choice.</p> <p>Observation on 06/03/24 at 6:45 A.M. with Dietary Manager #208 revealed initial food temperatures on the steam table as follows: egg cheese omelet 166 degrees Fahrenheit (F), sausage links 181 degrees F, pureed sausage 179 degrees F, pureed eggs 169 degrees F, oatmeal 172 degrees F, mechanical sausage 173 degrees F, white milk 31 degrees F, chocolate milk 32 degrees F, and apple juice 30 degrees F.</p> <p>Continuous observation of the breakfast tray line on 06/03/25 beginning at 7:09 A.M. with Dietary Manager #208 revealed Dietary Manager #208 was preparing trays. Hand hygiene, proper sanitation and portions were observed during tray line. At 7:46 A.M. Dietary Manager #208 confirmed she ran out of oatmeal and needed to use cold cereal for the four remaining trays for Residents #18, #22, #23, and #25. Dietary Manager #208 also confirmed they ran out of spoons and had to use plastic spoons for the last four trays as well. Tray line finished at 7:52 A.M. A test tray was prepared and sent on the last food cart. The food cart arrived on the east unit at 7:55 A.M. and the tray pass was initiated. The last resident food tray was passed at 8:06 A.M.</p> <p>Interview on 06/03/25 at 8:03 A.M. with Resident #33 revealed the food was cold and the kitchen does not always have enough for meals.</p> <p>Interview on 06/03/25 at 8:05 A.M. with Resident #48 revealed the kitchen always runs out of food and meals are cold.</p> <p>A test tray was completed with Dietary Manager #208 at 8:08 A.M. which revealed the following temperatures: Cheese Omelet 118 degrees F, Sausage 109 degrees F, Sausage 109 degrees F, Pureed Sausage 112.8 degrees F, pureed egg 106 degrees F and milk 65 degrees F. Taste test with Dietary Manger #208 at the time revealed Dietary Manager #208 confirmed the food was not warm enough for preference, and the pureed omelet was bland, tasteless, and did not have a desirable flavor.</p> <p>Review of the Resident Council Meeting Minutes dated 05/27/25 revealed the residents reported food concerns. Residents noted the meals were repetitive at times and residents requested more fresh fruit.</p> <p>Review of the facility policy Food Temperatures at Point of Service dated 07/14/23 revealed best efforts will be made to present hot food hot and cold foods cold at point of service by using thermal lids and bases, heated or chilled plate and thermal pellets as necessary. Food service will monitor the palatability of food at point of service by periodic test tray evaluation and review of resident council concerns.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/11/2025
NAME OF PROVIDER OR SUPPLIER  Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE  4360 Brecksville Rd Richfield, OH 44286	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>This deficiency represents non-compliance investigated under Complaint Numbers OH00165087 and OH00164461.</p>