STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365370	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Richfield	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)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on interview and record review, the facility failed to ensure resident authorized the facility to manage their personal funds and the authorization was witnessed by a third party. This affected two (Residents #30 and #207) of six residents reviewed for personal funds. The facility census was 54. Findings include: 1. Review of the closed medical record for Resident #30 revealed an admitted [DATE] with diagnoses including heart disease, anxiety and dementia. He was discharged on [DATE]. Review of the Resident Fund Management Service (RFMS), undated, for Resident #30 revealed handwriting at the top of the form stating Human Resources Director (HR) #343 had opened the account. She had explained to the resident and over the course of a month he would not sign and stated he needed to read the form over. Review of the RFMS trial balance list dated 03/10/25 revealed Resident #30 had a balance of $2,000.29. Interview on 03/18/25 at 8:43 A.M. with HR #343 verified Resident #30 passed away on 02/15/25. She stated he had a guardian for financial decisions. She stated she had attempted to have Resident #30 sign the RFMS authorization, however, he wanted to read the form and then refused to sign. HR #343 stated the money he had in his account came from another facility and was deposited in the RFMS account on 10/15/24. She verified Resident #30 had a financial guardian and she had not reached out to them for authorization. 2. Review of the closed medical record for Resident #207 revealed an admitted [DATE] with diagnoses including dementia and depression. She was discharged on [DATE]. Review of the RFMS, dated 06/04/20, for Resident #207 revealed the resident had not signed the form nor her representative. The form was also not witnessed by a third party. Review of the RFMS trial balance list dated 03/10/25 revealed Resident #207 had a balance of $5,239.68. (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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/18/25 at 8:43 A.M. with HR #343 verified Resident #207 passed away on 05/24/24. She verified the form was not signed or witnessed. Review of the facility policy titled, Resident Funds, dated 05/01/22, revealed the facility would establish uniform guidelines to protect personal funds managed by the facility on behalf of its residents. However, it did not state the process of having residents or their representatives sign for an RFMS account of have it witnessed by a third party.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on interview, record review, and facility policy review, the facility failed to ensure resident personal funds were disbursed to the resident's estate within 30 days. This affected two (Residents #30 and #207) of two residents reviewed for personal funds after death. The facility census was 54. Findings include: 1. Review of the closed medical record for Resident #30 revealed an admitted [DATE] with diagnoses including heart disease, anxiety and dementia. He passed away on 02/15/25. Review of the Resident Fund Management Service (RFMS) trial balance list dated 03/10/25 revealed Resident #30 had a balance of $2,000.29. Interview on 03/18/25 at 8:43 A.M. with Human Resource Director (HR) #343 verified Resident #30 passed away on 02/15/25. She stated he had a guardian for financial decisions who she had attempted to contact. She was unaware of the required time frame to disperse the funds to his estate. 2. Review of the closed medical record for Resident #207 revealed an admitted [DATE] with diagnoses including dementia and depression. Resident #207 passed away on 05/24/24. Review of the RFMS trial balance list dated 03/10/25 revealed Resident #207 had a balance of $5,239.68. Interview on 03/18/25 at 8:43 A.M. with HR #343 verified Resident #207 passed away on 05/24/24. She stated Resident #207 had a financial power-of-attorney. She was unaware of the required time frame to disperse the funds to her estate. Review of the facility policy titled, Resident Funds, dated 05/01/22, revealed the facility would establish uniform guidelines to protect personal funds managed by the facility on behalf of its residents. However, it did not state the process of funds being disbursed after a resident had passed away.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on observation, interview, and record review, the facility failed to ensure residents were able to use the phone when requested and in private. This affected one (Resident #206) of one resident reviewed for facility phone usage. The facility census was 54. Findings include: Review of the medical record for Resident #206 revealed an admitted [DATE] with diagnoses including bipolar disorder (mental health condition that causes mood swings), anxiety and hypertension. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #206 had adequate hearing, clear speech, understood others and was able to be understood. He had impaired cognition. It was noted under section F for preferences for routines and activities that it was very important for him to use a phone in private. Interview on 03/18/25 at 7:40 A.M. with Licensed Practical Nurse (LPN) #325 revealed residents had access to a phone but would have to use the corded phone at the nurse's station. The phone number would be dialed and then handed through a hole in the plastic that sat on top of the nursing station counter. The resident would then have to use the phone in the hallway. She stated she was unaware of other private phones for the residents to utilize. Observation and interview on 03/18/25 at 4:50 P.M. of Resident #206 revealed he wanted to use the phone at the west nursing station. He stated to LPN #325 that he needed to call someone and asked to use the phone. LPN #325 stated he could not use the phone as she had two admissions. Resident #206 then left the nursing station. LPN #325 stated Resident #206 had asked her six times to use the phone already and she was busy with admissions. She verified she had refused to allow him to use the phone. Interview on 03/19/25 at 8:10 A.M. with Resident #206 verified he did eventually get to use the phone on 03/18/25. He stated there was no privacy with phone use as the nursing staff handed a corded phone out and he had to talk on the phone in the hallway. The facility was unable to provide a policy on phone use or resident privacy with phone calls.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, interview and facility policy review, the facility failed to ensure advance directive orders were consistent across electronic and paper medical records. This affected five residents (#7, #15, #20, #25 and #34) out of 24 resident records reviewed. The facility census was 54. Findings include: 1. Review of Resident #7's medical record revealed an admitted [DATE] and diagnoses including schizoaffective disorder, hypertension, insomnia, muscle weakness and diabetes. Review of Resident #7's electronic medical record (EMR) revealed he had an advance directive of Do Not Resuscitate Comfort Care Arrest (DNRCCA) (indicating no life-sustaining interventions would be attempted in the event of cardiac or respiratory arrest). Review of Resident #7's paper medical record revealed he had an advance directive of full code, indicating life-sustaining interventions, including cardiopulmonary resuscitation (CPR) would be attempted in the event of cardiac or respiratory arrest). Interview on [DATE] at 3:34 P.M. with Social Service Designee (SSD) #355 indicated she was knowledgeable on many residents' advance directives due to conducting plan of care meetings. SSD #355 verified Resident #7's paper medical record was not accurate as he did not have an advance directive of full code. 2. Review of Resident #15's medical record revealed an admitted [DATE] and diagnoses including dementia with agitation, alcohol dependence with alcohol-induced persisting dementia, generalized anxiety disorder, paranoid personality disorder and delusional disorders. Review of Resident #15's EMR revealed he had an advance directive of DNRCCA. Review of Resident #15's paper medical record revealed he had an advance directive of full code. No signed Do Not Resuscitate (DNR) form was available in the resident's record. Interview on [DATE] at 3:34 P.M. with SSD #355 verified Resident #15's paper medical record was not accurate and did not match the EMR as Resident #15 did not have an advance directive of full code and no signed DNR was available in his chart. 3. Review of Resident #20's medical record revealed an admitted [DATE] and diagnoses including type two diabetes, chronic kidney disease, traumatic brain injury, dementia with agitation and generalized anxiety disorder. Review of Resident #20's EMR revealed he had an advance directive of DNRCCA. Review of Resident #20's paper medical record revealed he had an advance directive of full code. No signed DNR form was available in his record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 3:34 P.M. with SSD #355 verified Resident #20's paper medical record was not accurate and did not match the EMR as Resident #20 did not have an advance directive of full code and no signed DNR form was available in his chart. 4. Review of Resident #25's medical record revealed an admitted [DATE] and diagnoses including traumatic brain injury, insomnia, protein-calorie malnutrition, vascular dementia with other behavioral disturbance, anxiety and depression. Review of Resident #25's EMR revealed he had an advance directive of DNRCCA. Review of Individual #25's paper medical record revealed a face sheet stating he had an advance directive of DNRCCA, but no signed DNR form was available in his record. Interview on [DATE] at 3:34 P.M. with SSD #355 verified Resident #25's paper medical record was not complete as no signed DNR form was available in his chart. 5. Review of Resident #34's medical record revealed an admitted [DATE] and diagnoses including vascular dementia with psychotic disturbance, paranoid personality disorder, violent behavior, osteoarthritis and depression. Review of Resident #34's EMR revealed he had an advance directive of DNRCCA. Review of Individual #34's paper medical record he had an advance directive of full code. No signed DNR form was available in his record. Interview on [DATE] at 3:34 P.M. with SSD #355 revealed the previous DON responsible for ensuring residents had advance directives in place but the facility had a new DON at this time. SSD #355 indicated she was knowledgeable on many residents' advance directives due to conducting plan of care meetings. SSD #355 verified Resident #34's paper medical record was not accurate and did not match the EMR as Resident #34 did not have an advance directive of full code and no signed DNR was available in his chart. Review of the facility policy, Advance Directives, dated [DATE] revealed upon admission the social worker and/or admission director will furnish information on advance directives. When a social worker is not available the Registered Nurse (RN) supervisor will give and review advance directive information and document in the medical record. A Do Not Resuscitate order is honored upon admission after reviewed with the individual/family member or surrogate by the social worker/or admission RN when they arrive to the facility to ensure continuation. Residents with DNR orders will be identified on the face sheet and in the resident's medical record Resident's advance directives will be reviewed upon admission, re-admission from the hospital, quarterly and annually by the social worker. Staff with direct care responsibilities will be knowledgeable of the location of resident's resuscitative status information throughout the facility. All facility staff including non direct care employees and temporary agency staff will be aware of facility procedure if they encounter a resident's arrest.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 44457 Based on observations, staff and resident interviews, and facility policy review, the facility failed to ensure a safe, clean, homelike environment by ensuring water temperatures reached appropriate and homelike temperatures, and blinds, ceiling tiles, walls, door frames, and hand rails were without the need for repair. This affected all residents residing in the facility. The facility census was 54. Findings include: 1. Interview on 03/10/25 at 10:01 A.M. with Resident #48 revealed the water was cold and the water pressure was low. Resident #48 indicated the shower room was broken. Interview on 03/10/25 at 10:29 A.M. with Resident #203 revealed the shower was broken and he had been unable to get a shower. Observation and interview on 03/10/25 at 10:29 A.M. with Resident #23 revealed her toilet had not been working for a week and Resident #23 reported the shower room was broken. Observation of Resident #23's toilet revealed it was not secured to the floor. Resident #23 reported hot water was also an issue, stating it was either too hot or too cold. Observation and interview on 03/10/25 at 12:01 P.M. with Resident #27 revealed the resident had asked where she could use the bathroom and stated her toilet did not work. Housekeeper #311 was nearby and indicated she could use the one in her room. Housekeeper #311 went into Resident #27's bathroom in her room and confirmed the toilet was not secured to the floor and was not working appropriately. The bathroom was shared between two rooms, including Resident #23. Resident #27 was assisted by staff to a bathroom down the hall. Observations on 03/10/25 from 12:18 P.M. to 12:55 P.M. revealed a sign on the west side shower room indicating Do not use shower. Out of order. Interview on 03/10/25 at 12:22 P.M. with Resident #22 revealed the shower room had not been working all weekend and he was unable to get a shower. Resident #22 stated the backed up water leaked out into the hallway. Interview on 03/10/25 at 12:49 P.M. with Resident #44 revealed she could get showers, but the water was cold. Follow up tour on 03/10/25 from 1:00 P.M. to 1:10 P.M. with the Administrator revealed the shower room had been fixed and it had been out of order since 03/07/25. Interview on 03/11/25 at 1:08 P.M. with the Administrator revealed she was unable to find any logged water temperatures or maintenance records for the last 12 months. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Follow up tour on 03/12/25 from 9:45 A.M. to 10:05 A.M. with Housekeeping and Maintenance Supervisor (HMS) #306 revealed most residents shared a bathroom between two rooms, but there were a few with private bathrooms. HMS #306 indicated there were no showers in resident rooms, and there were two shower rooms in the facility. Observation of water temperatures on 03/12/25 from 11:16 A.M. to 12:19 P.M. with HMS #306 using the facility's digital thermometer revealed the following: Resident #18's sink water temperature was 101.5 degrees Fahrenheit (F). Resident #49's sink water temperature was 99.1 degrees F. Resident #48 and #203's sink water temperature was 101.9 degrees F. Resident #31 and Resident #45's sink water temperature was 96.1 degrees F. Resident #20's sink water temperature was 77.0 degrees F. Resident #5's sink water temperature was 90.5 degrees F. Resident #15's sink water temperature was 102.6 degrees F. Resident #14's sink water temperature was 98.4 degrees F. Resident #104's sink water temperature was 101.5 degrees F. Resident #205's sink water temperature was 81.7 degrees F. The [NAME] side shower room shower was 81.0 degrees F. The East side shower room shower was 97.3 degrees F. Interview during the observation of water temperatures on 03/12/25 from 11:16 A.M. to 12:19 P.M. with Resident #49 revealed the water was never hot. Interview during the observation of water temperatures on 03/12/25 from 11:16 A.M. to 12:19 P.M. with Resident #5 revealed the water did not get hot no matter how long it ran. Interview on 03/12/25 at 11:42 A.M. with HMS #306 confirmed the water temperatures throughout the building were not within a comfortable range. HMS #306 indicated he had recently taken over the maintenance supervisor position and was unsure how to adjust the water temperatures. HMS #306 indicated the water was heated by a boiler system. HMS #306 indicated this was the first time he had taken water temperatures. Review of the facility policy titled Water Temperature dated 05/01/22 revealed maintenance was responsible for checking temperature controls of water in the facility and recording the checks in a maintenance log. Water temperatures would be no more than 120 degrees. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observations on 03/10/25 from 12:18 P.M. to 12:55 P.M. revealed Resident #8, Resident #34 and Resident #46 were observed with broken blinds in their rooms. Interview on 03/10/25 at 12:50 P.M. with Resident #46 revealed the blinds in his room had been broken since he moved in. Follow up tour on 03/10/25 from 1:00 P.M. to 1:10 P.M. with the Administrator confirmed the environmental findings for Resident #8, #34, and #46. Follow up interview and tour on 03/12/25 from 9:45 A.M. to 10:05 A.M. with HMS #306 revealed Resident #38's room had broken mini blinds. The observations were confirmed with HMS #306 at the time of the observation. Observation on 03/12/25 from 11:16 A.M. to 12:19 P.M. with HMS #306 revealed Resident #104's mini blinds were broken in their room and Resident #5's mini blinds were broken in their room. Interview during the observation on 03/12/25 from 11:16 A.M. to 12:19 P.M. with HMS #306 confirmed findings in Resident #5's room and Resident #104's room. 3. Observations on 03/10/25 from 12:18 P.M. to 12:55 P.M. revealed multiple discolored ceiling tiles observed across from the west side nursing station, in the hallway outside Resident #21 and Resident #15's room, in the east side shower room, and in hallway outside Resident #14's room. There were multiple patched and unpainted dents in walls on the memory care unit. The paint was chipped on the door frame leading to the 100 hallway, and there was paint chipped off the doors of Resident #37, Resident #33, Resident #8, Resident #1, Resident #23, and Resident #19's rooms. Resident #38's room had dented and paint chipped walls. There was a piece of plywood leaning against the wall in the occupied room. Resident #40's room had numerous white unpainted patches on the walls and there was blue painters' tape around cabinets, door frames, and lights. Interview on 03/10/25 at 12:45 P.M. with Certified Nursing Assistant (CNA) #317 reported there was not a maintenance person currently and there was no one to report issues to. CNA #317 indicated if there was some kind of emergency she would report it to housekeeping. Follow up tour on 03/10/25 from 1:00 P.M. to 1:10 P.M. with the Administrator confirmed the above environmental findings. The Administrator indicated there were some ceiling leaks when the ice was melting with the temperature changes. Interview on 03/11/25 at 1:08 P.M. with the Administrator revealed she was unable to find any maintenance records for the last 12 months, including maintenance records regarding the discolored ceiling tiles, dents on the memory care walls, paint chipping from the doorway in the 100 hall, and paint chipping from the residents doors. Follow up tour on 03/12/25 from 9:45 A.M. to 10:05 A.M. with HMS #306 revealed Resident #38's room also had two discolored and sagging ceiling tiles. Resident #1 and Resident #23's shared room was observed with a vanity with a missing drawer and mirror and it had two cabinet doors hanging off the hinges. The observations were confirmed with HMS #306 at the time of the observation. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 03/12/25 from 11:16 A.M. to 12:19 P.M. with HMS #306 revealed large holes were observed in the wall behind Resident #5's headboard. Interview during the observation on 03/12/25 from 11:16 A.M. to 12:19 P.M. with HMS #306 confirmed the findings in Resident #5's room. 4. Observations on 03/10/25 from 12:18 P.M. to 12:55 P.M. revealed the handrail extending between rooms #13 and #14 was loose on the wall, the handrail extending between rooms #36 and #37 was loose on the wall, and the handrail extending from the east side shower room door to the corner of the wall was loose. Interview on 03/10/25 at 12:45 P.M. with Certified Nursing Assistant (CNA) #317 reported there was not a maintenance person currently and there was no one to report issues to. CNA #317 indicated if there was some kind of emergency she would report it to housekeeping. Follow up tour on 03/10/25 from 1:00 P.M. to 1:10 P.M. with Administrator confirmed the above findings. Interview on 03/11/25 at 1:08 P.M. with Administrator revealed she was unable to find any maintenance records for the last 12 months. This deficiency represents non-compliance investigated under Complaint Number OH00162361.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on review of a self-reported incident (SRI), review of the facility policy, record review and interview, the facility failed to prevent resident-to-resident physical abuse. This affected one resident (#23) out of five residents reviewed for abuse. Facility census was 54. Findings include: Review of Resident #23's medical record revealed an admitted [DATE] and diagnoses including lumbago, low back pain, general anxiety disorder and post-traumatic stress disorder. Resident #23 was her own responsible party. Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had a brief interview for mental status (BIMS) score of 14, indicating she was cognitively intact and displayed other behaviors one to three days of the seven-day look-back period. Review of Resident #23's plan of care dated 09/18/24 and revised 12/19/24 revealed Resident #23 had delusions, behavior problems and could attempt to manipulate with physical aggression, verbal aggression and emotional outbursts and was also noted to make false accusations. Review of a nurses' note dated 09/29/24 at 8:00 P.M. and authored by Licensed Practical Nurse (LPN) #327 revealed this nurse was notified of incident regarding this resident and co-resident. Resident #23 states that co-resident threw water at her, hit her with a wet floor sign, and a shoe. Resident #23 was observed sitting in wheelchair, wet and sobbing. Vitals taken, and resident skin assessed. This nurse noticed a small skin tear near Resident #23's heel. Resident #23 also complained of being sore after incident. This nurse escorted Resident #23 to bed and administered as-needed (PRN) pain medication along with before bed medications. Resident #23 was in compliance with neuro-checks and every 15-minute (Q15) safety checks. Resident #23 was in bed meditating, call light within reach and safety maintained. Physician and Director of Nursing (DON) notified. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an interdisciplinary team note dated 09/30/24 at 4:46 P.M. and authored by Registered Nurse (RN) #313, who was the facility's DON at the time of the resident-to-resident altercation, revealed upon investigating physical altercation that occurred with male resident, Resident #23 alleges that male resident attacked her while coming from smoke break. Resident #23 alleges that he rode up in his motorized wheelchair, threw up a cup of water at her then proceeded to hit her in the head with wet floor sign. Resident #23 also alleges that Resident #10 hit her repeatedly with his house-shoe. Resident #23 states that altercation was unprovoked and denies any verbal exchange proceeding incident. This DON and Assisted Director of Nursing (ADON)/LPN #368 conducted interviews with nursing staff and residents present at time of altercation. Statements conclude that Resident #23 was being followed by male resident and that he ran up against her in motorized wheelchair. He then hit Resident #23 several times with house-shoe at the back of her head. While turning around to defend herself Resident #23 lost balance falling out of wheelchair onto her back and buttocks. Resident #23 does report complaints of headache, neck, and upper back soreness rated 8/10. PRN pain medications administered and effective with pain complaints at this time. Resident #23 was asked if she felt she needed emergency evaluation, resident states, No I should be fine. Resident educated by this nurse during assessment to notify nursing staff of increased pain. Neuro-checks and fall follow-up initiated at time of incident. Skin assessment completed by this nurse. Skin clear and intact at this time, with exception to a small skin tear of 0.2 centimeters (cm) by 0.1 cm to posterior ankle which is now scabbed over. No signs or symptoms of infection present at this time. Area is to be left open to air and monitored by nursing staff. Physician notified of altercation, resident who responsible for self is currently stable and 15 minute-checks in place for safety intervention at this time. Review of Resident #10's closed medical record revealed an admitted [DATE] and diagnoses including schizoaffective disorder, type two diabetes, depression, dysphagia and aphonia. Resident #10 was his own responsible party. Resident #10 discharged to an assisted living facility on 03/12/25. Review of a quarterly MDS assessment dated [DATE] revealed Resident #10 had a BIMS score of 14, indicating he was cognitively intact. Resident #10 displayed verbal behaviors four to six days out of the seven-day look-back period. Review of Resident #10's plan of care dated 04/10/24 and revised 10/02/24 revealed Resident #10 had impaired mood coupled with behaviors. Resident #10 had a history of being verbally aggressive and antagonist as well as physically aggressive with recent incidents on 09/25[/2024] and 09/29[/2024]. Review of a nurse's note dated 09/29/24 at 9:54 P.M. and authored by RN #348 revealed at approximately 8:00 P.M. this nurse was called to for incident involving Resident #10 and a co-Resident. Resident #10 stated that co-Resident struck him with an umbrella and Resident #10 retaliated by hitting her with his shoe. Resident #10 was assessed and obtained no injuries from altercation. Vitals were within normal limits and no complaints of pain were voiced. Resident is aware and in agreement of 15-minute checks for the next 48 hours as Resident #10 is his own responsible party. Physician and DON notified. Review of a facility SRI dated 09/29/24 revealed an allegation of physical abuse between Resident #10 and Resident #23. Resident #10 initiated physical altercation with Resident #23 during smoke break and hit Resident #23 with a house-shoe. Interviews, assessments and notifications were completed and the facility substantiated the allegation of resident-to-resident physical abuse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE: 4360 Brecksville Rd Richfield, OH 44286	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a witness statement dated 09/29/24 and authored by Certified Nursing Assistant (CNA) #353 revealed the following information: I was on the patio [with] the smoking residents at 7:35 P.M. At 7:45 P.M. Resident #23 was finished smoking and went into the building and stopped in the hallway to talk to two other residents. Resident #10 came down the hall and behind Resident #23's wheelchair and started hitting Resident #23 in the back of her head from behind with his blue tennis shoe. Resident #23 started screaming and turned around to try to defend herself resulting in her wheelchair tipping backwards and Resident #23 falling out of her wheelchair. Resident #10 took off back down the hallway. I notified the nurse (not identified) and spoke to the DON. Review of a witness statement dated 09/29/24 and authored by LPN #327 revealed the following information: I was not around to witness this incident. After the incident occurred I did witness Resident #23 sobbing and wet in her wheelchair. Review of a witness statement dated 09/29/24 and authored by RN #313 on behalf of Resident #31 revealed the following information: I was sitting down next to Resident (not fully identified) and we were ordering chicken wings. Resident #23 comes around the corner screaming for her life and Resident #10 comes behind Resident #23 and hits her repeatedly in the back of her head with his shoe. Resident #23 turned around to defend herself and fell out of her wheelchair. The CNA (not identified) called for some back-up to help her. Resident #10 went around the corner and fled the scene. I did not see Resident #23 hit Resident #10 with anything. Interview on 03/10/25 at 10:29 A.M. with Resident #23 reported she had past issues with Resident #10, including being hit with his shoe. Interview on 03/19/25 at 11:13 A.M. with Chief Operating Officer (COO) #300 verified the content of the above SRI investigation between Resident #10 and Resident #23 on 09/29/24 and confirmed it was substantiated for resident-to-resident physical abuse. Review of the facility policy, Abuse Prevention, dated 08/20/21 revealed the facility would not tolerate abuse, neglect, exploitation of its residents or misappropriation of resident property. The facility would complete the assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms, residents with self-injurious behaviors, residents with communication disorders and those that require heavy nursing care and/or are totally dependent on staff as part of its abuse prevention and identification interventions. The policy did not have specific response protocols for instances of resident-to-resident abuse. This deficiency represents noncompliance investigated under Complaint Number OH00162361.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on review of a self-reported incident (SRI), review of the facility policy, record review and interview, the facility failed to timely report allegations of misappropriation and injury of unknown origin. This affected two residents (#18 and #23) out of five residents reviewed for abuse. Facility census was 54. Findings include: 1. Review of Resident #23's medical record revealed an admitted [DATE] and diagnoses including lumbago, low back pain, general anxiety disorder and post-traumatic stress disorder. Resident #23 was her own responsible party. Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had a brief interview for mental status (BIMS) score of 14, indicating she was cognitively intact and displayed other behaviors one to three days of the seven-day lookback period. Review of Resident #23's plan of care dated 09/18/24 and revised 12/19/24 revealed Resident #23 had delusions, behavior problems and could attempt to manipulate with physical aggression, verbal aggression and emotional outbursts and was also noted to make false accusations. Review of a SRI dated 01/06/25 at 5:08 P.M. revealed Resident #23 reported to Registered Nurse (RN) #313, the Director of Nursing (DON) at the time of the allegation, that her tablet was missing. Resident #23 stated a Certified Nursing Assistant (CNA) who was taking care of her removed her dinner tray that the tablet was on. The time of the occurrence was identified as 01/06/25 at 3:07 P.M. An alleged perpetrator was listed as CNA #329. A search was completed for the tablet and the tablet was not found. Resident #23 was offered a lock box which she declined. The facility determined the allegation of misappropriation to be unsubstantiated. Review of the facility's investigation for the SRI on 01/06/25 revealed two sheets of paper including a statement from Social Service Designee (SSD) #355 and a statement from CNA #353. No further evidence of investigation was available for review. Review of the statement dated 01/07/25 and authored by SSD #355 revealed the following information: I interviewed Resident #23 on 01/07/25 and she stated she had an iPad (tablet) that was missing. Resident #23 stated she has two iPads, one with a purple and blue case and another Amazon iPad with a black case that had googly eyes and the words do not touch on the front of it. Resident #23 stated the iPad was on her tray table on top of her food tray and that it was removed by a CNA and never returned. An addendum was located at the bottom of SSD #355's statement which indicated on 01/10/25 Resident #23 found her missing iPad but no further information was available. Review of the statement dated 01/09/25 and authored by CNA #353 revealed she had no knowledge of Resident #23's tablet. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's grievance and self-report tracking log for January 2025 revealed on 01/04/25, Resident #23 had reported her missing iPad. Under the 'Resolution' header, there was a notation the iPad was found on 01/10/25. Interview on 03/12/25 at 11:09 A.M. with Resident #23 revealed in January 2025, her tablet was laying on her meal tray. Resident #23 identified her tablet as an Amazon Fire tablet, which she showed the surveyor during the interview. This tablet had a black cover with white writing with Resident #23's initials and the phrase don't touch my tablet on it. Resident #23 stated CNA #329 picked up her meal tray and took the tablet, then sold her tablet to Resident #10 for $100.00. She was able to activate an alarm on her tablet from her cell phone, which she found in Resident #10's room. Resident #23 could not state how much time had elapsed from when the tablet was observed gone to the time she found it in Resident #10's room. Resident #23 shared she had two Amazon Fire tablets, a 9-inch one and an 11-inch one and indicated the 9-inch one was the one that had been reported missing. Resident #23 verified the facility did not interview her regarding her allegation of misappropriation or have her write a witness statement. Interview on 03/12/25 at 11:22 A.M. with CNA #329 revealed she was angry she was suspended over the allegation of misappropriation regarding Resident #23's missing tablet. CNA #329 stated she worked on 01/05/25 and did not have Resident #23 as her resident that date. CNA #329 reported Resident #23 made the complaint at lunch regarding her missing tablet, so she told Licensed Practical Nurse (LPN) #329 and CNA #353. CNA #353 had went into the kitchen to look through the trash for Resident #23's tablet and an agency nurse (not identified) was also aware of the missing tablet. On 01/06/25, the previous Director of Nursing (DON), RN #313 and previous Assistant Director of Nursing (ADON)/LPN #368 told her she was being suspended over the theft of Resident #23's tablet. CNA #329 stated she was not interviewed and the facility did not have her write a witness statement. CNA #329 stated they had her come in on 01/08/25 as the facility had found Resident #23's tablet as SSD #355 observed Resident #23 on the tablet and Resident #23 stated at that time CNA #329 had stole the tablet, sold it to Resident #10 then got her tablet back. Interview on 03/12/25 at 11:38 A.M. with LPN #354 revealed she did not recall Resident #23's missing iPad and shared Resident #23 was always on an iPad in her room. Interview on 03/12/25 at 11:45 A.M. with CNA #353 revealed she was aware of the allegation of misappropriation regarding Resident #23 and confirmed she had to write a witness statement. First, Resident #23 said a resident stole her iPad and she hit an alarm on it and it went off. Then, Resident #23 stated a kitchen staff had stolen her iPad and then she accused CNA #329 of stealing the iPad. CNA #353 stated the iPad was missing maybe four or five days, then it reappeared. Interview on 03/12/25 at 11:53 A.M. with SSD #355 revealed she was in charge of keeping the facility's grievance and self-report tracking log. SSD #355 recalled someone (name not provided) had told her about the allegation and stated a CNA had taken Resident #23's meal tray which had her tablet on it and Resident #23 had thought someone had sold it to Resident #10. SSD #355 stated Resident #23 later found her tablet in Resident #10's room. When asked about the facility's grievance and self-report tracking log and the date of 01/04/25 regarding Resident #23's concern with her missing tablet, SSD #355 verified the date of 01/04/25 was accurate and was the date she was first made aware of Resident #23's missing tablet. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/25 at 12:12 P.M. the Chief Operating Officer (COO) #300 was notified the allegation of misappropriation regarding Resident #23's missing tablet was first reported to SSD #355 on 01/04/25, but the facility failed to file a SRI regarding the misappropriation until 01/06/25. COO #300 verified the SRI was not reported timely as required per facility policy and procedure. 44457 2. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including Parkinson's disease, age-related osteoporosis, dementia, generalized muscle weakness, and dependence on wheelchair. Resident #18 was hospitalized from 01/18/25 to 01/20/25. Review of a nurse's note dated 01/03/25 at 7:35 A.M. revealed Resident #18 was found on floor by nurse aide lying flat on her back. Nurse and aide picked Resident #18 up off the floor and into her wheelchair. Resident #18 was taken to the dining room for breakfast. Resident #18 stated she got up from her recliner chair to pick something up off the floor and fell backwards. It was noted Resident #18 claimed she didn't hit her head and had no complaints of pain at this time. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #18 had severely impaired cognition and was dependent on staff for activities of daily living (ADLs). Review of a nurse's note dated 01/18/25 at 9:55 A.M. revealed Resident #18's was sent to hospital for evaluation related to abdominal pain and suspicious x-ray of abdomen. Review of a Hospital Medicine History and Physical dated 01/18/25 revealed Resident #18 presented to hospital for concern of bowel obstruction. While in the emergency department (ED) a cat (CT) scan was completed, and Resident #18 was noted to have a fracture of the pelvis. CT results showed acute fractures of left hemipelvis involving the left superior and inferior pubic rami extending towards the medial left acetabulum. Orthopedics were following; however, the fracture was nonsurgical. Resident #18's sister was present at hospital and reported on 01/03/25 Resident #18 had a fall and had been complaining of pain to left hip since. Physical examination showed edema to right lower extremity and trace edema to left hip. Resident #18 had pain to the left hip inguinal fold area and when laying on side. Review of the Hospital Discharge Summary dated 01/20/25 revealed diagnoses including closed nondisplaced fracture of pelvis, chronic constipation, and cellulitis of extremity. Review of a nurse's note dated 01/20/25 at 3:29 P.M. revealed the hospital reported Resident #18 had pelvic fracture with no surgical interventions. Resident #18 would return to facility weight bearing as tolerated. Review of a nurse's note dated 01/20/25 at 6:30 P.M. revealed Resident #18 returned to the facility from the hospital. Review of a NP progress note dated 01/21/25 revealed Resident #18 readmitted to facility from hospital with diagnoses of left pelvic fracture. The NP noted prior to admission Resident #18 was totally dependent on staff for ADL care needs. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/18/25 at 8:00 A.M. with Resident #18's sister revealed she had made an allegation of neglect in January 2025 and had provided videos as supporting evidence to facility staff. During the interview, the resident's sister also shared Resident #18 had a fall at the beginning of January 2025. An x-ray was completed that did not show a fracture; however, Resident #18 was in pain following the incident and was unable to advocate for herself. The resident's sister revealed around the middle of January 2025 Resident #18's stomach was hard and full for a few days and she was having edema. The sister indicated while at the hospital Resident #18 was found to have a hip fracture. Review of a family provided two minute and one second video dated 01/04/25 at 9:08 A.M. revealed Resident #18 was receiving incontinence care while in bed from Nurse Aide #329 and Nurse Aide #353. Resident #18 could be heard groaning when turned by the staff. During turning at the one minute and 39 second mark Resident #18 could be heard saying ouch and says ow again at the one minute and 57 second mark while staff were attempting to re-dress the resident. Review of a family provided one minute and 28 second video dated 01/04/25 at 11:20 A.M. revealed Resident #18 was being prepared for transfer using sit to stand lift by Nurse Aide #329 and Nurse Aide #353. At the 34 second mark Nurse Aide #329 pulls Resident #18's legs to edge of bed and the resident could be heard groaning (in pain) out loudly. Review of an email provided by Resident #18's sister dated 01/05/25 timed 8:35 P.M. revealed Resident #18's sister contacted the former Administrator, former DON, Social Services Designee (SSD) #355, and Ombudsman with her concerns. In the email, Resident #18's sister noted the resident fell on [DATE] and hurt her left hip and leg. The sister indicated an x-ray was taken about 6:00 P.M. on 01/03/25; however, she did not receive notification of results until 01/04/25 at 9:45 A.M. The sister indicated it was apparent Resident #18 was in pain; however, she was not made aware of a treatment plan in place. The sister stated Resident #18 was unable to request pain medications. The sister included a series of videos in the email from a camera in Resident #18's room. The sister indicated on video Nurse Aide #329 was not gentle and did not appear to be knowledgeable of Resident #18's potentially broken left hip. The sister shared additional unrelated concerns related to the care of Resident #18 in the email. Review of a facility Self-Reported Incident (SRI) dated 01/06/25 at 9:30 A.M. revealed Resident #18's sister made an allegation Nurse Aide #329 was rough during incontinence care. The resident's recent fall with pain was not included on the SRI investigation. Further review revealed there was no evidence of SRI filed for Resident #18's 01/18/25 pelvic fracture to rule out potential abuse. During an interview on 03/18/25 at 2:04 P.M. with the Administrator and Chief Operating Officer (COO) #300, Resident #18's fall on 01/03/25, SRI on 01/06/25, and pelvic fracture on 01/18/25 were reviewed. COO #300 indicated she was unable to remember any details of Resident #18's fall. COO #300 and the Administrator confirmed they were unable to provide any additional details related to Resident #18's fall and subsequent fracture including interventions, investigation, interdisciplinary review, or root cause analysis. COO #300 confirmed there was no reporting of injury of unknown origin to rule out abuse for Resident #18. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Abuse Prevention dated 08/20/21 revealed the facility would investigate all alleged violations involving abuse including injuries of unknown origin. An injury of unknown origin is classified when the source of injury was not observed or could be explained by the resident and the injury is suspicious due to extent/location/number of injuries or injuries over time. Serious bodily injuries should be reported to Ohio Department of Health (ODH) immediately or no later than 2 hours after alleged incident. Follow up was required for injuries of unknown source to make necessary changes in resident's plan of care to protect against occurrence of another similar injury. This deficiency represents non-compliance investigated under Complaint Number OH00162361.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on review of a self-reported incident, review of the facility policy, record review and interview, the facility failed to thoroughly investigate allegations of misappropriation and injury of unknown origin. This affected two residents (#18 and #23) out of five residents reviewed for abuse Facility census was 54. Findings include: 1. Review of Resident #23's medical record revealed an admitted [DATE] and diagnoses including lumbago, low back pain, general anxiety disorder and post-traumatic stress disorder. Resident #23 was her own responsible party. Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had a brief interview for mental status (BIMS) score of 14, indicating she was cognitively intact and displayed other behaviors one to three days of the seven-day lookback period. Review of Resident #23's plan of care dated 09/18/24 and revised 12/19/24 revealed Resident #23 had delusions, behavior problems and could attempt to manipulate with physical aggression, verbal aggression and emotional outbursts and was also noted to make false accusations. Review of a SRI dated 01/06/25 at 5:08 P.M. revealed Resident #23 reported to Registered Nurse (RN) #313, the Director of Nursing (DON) at the time of the allegation, that her tablet was missing. Resident #23 stated a Certified Nursing Assistant (CNA) who was taking care of her had removed her dinner tray that the tablet was on. The time of the occurrence was identified as 01/06/25 at 3:07 P.M. An alleged perpetrator was listed as CNA #329. A search was completed for the tablet and the tablet was not found. Resident #23 was offered a lock box which she declined. The facility determined the allegation of misappropriation to be unsubstantiated. Review of the facility's investigation for the SRI on 01/06/25 revealed two sheets of paper including a statement from Social Service Designee (SSD) #355 and a statement from CNA #353. No further evidence of investigation was available for review. Review of the statement dated 01/07/25 and authored by SSD #355 revealed the following information: I interviewed Resident #23 on 01/07/25 and she stated she had an iPad (tablet) that was missing. Resident #23 stated she has two iPads, one with a purple and blue case and another Amazon iPad with a black case that had googly eyes and the words do not touch on the front of it. Resident #23 stated the iPad was on her tray table on top of her food tray and that it was removed by a CNA and never returned. An addendum was located at the bottom of SSD #355's statement which indicated on 01/10/25 Resident #23 found her missing iPad but no further information was available. Review of the statement dated 01/09/25 and authored by CNA #353 revealed she had no knowledge of Resident #23's tablet. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's grievance and self-report tracking log for January 2025 revealed on 01/04/25, Resident #23 had reported her missing iPad. Under the 'Resolution' header, there was a notation the iPad was found on 01/10/25. Interview on 03/12/25 at 11:09 A.M. with Resident #23 revealed in January 2025, her tablet was laying on her meal tray. Resident #23 identified her tablet as an Amazon Fire tablet, which she showed the surveyor during the interview. This tablet had a black cover with white writing with Resident #23's initials and the phrase don't touch my tablet on it. Resident #23 stated CNA #329 picked up her meal tray and took the tablet, then sold her tablet to Resident #10 for $100.00. She was able to activate an alarm on her tablet from her cell phone, which she found in Resident #10's room. Resident #23 could not state how much time had elapsed from when the tablet was observed gone to the time she found it in Resident #10's room. Resident #23 shared she had two Amazon Fire tablets, a 9-inch one and an 11-inch one and indicated the 9-inch one was the one that had been reported missing. Resident #23 verified the facility did not interview her regarding her allegation of misappropriation or have her write a witness statement. Interview on 03/12/25 at 11:22 A.M. with CNA #329 revealed she was angry she was suspended over the allegation of misappropriation regarding Resident #23's missing tablet. CNA #329 stated she worked on 01/05/25 and did not have Resident #23 as her resident that date. CNA #329 reported Resident #23 made the complaint at lunch regarding her missing tablet, so she told Licensed Practical Nurse (LPN) #329 and CNA #353. CNA #353 had went into the kitchen to look through the trash for Resident #23's tablet and an agency nurse (not identified) was also aware of the missing tablet. On 01/06/25, the previous Director of Nursing (DON), RN #313 and previous Assistant Director of Nursing (ADON)/LPN #368 told her she was being suspended over the theft of Resident #23's tablet. CNA #329 stated she was not interviewed and the facility did not have her write a witness statement. CNA #329 stated they had her come in on 01/08/25 as the facility had found Resident #23's tablet as SSD #355 observed Resident #23 on the tablet and Resident #23 had stated at that time CNA #329 had stole the tablet, sold it to Resident #10 then got her tablet back. Interview on 03/12/25 at 11:38 A.M. with LPN #354 revealed she did not recall Resident #23's missing iPad and shared Resident #23 was always on an iPad in her room. Interview on 03/12/25 at 11:45 A.M. with CNA #353 revealed she was aware of the allegation of misappropriation regarding Resident #23 and confirmed she had to write a witness statement. First, Resident #23 said a resident stole her iPad and she hit an alarm on it and it went off. Then, Resident #23 stated a kitchen staff had stolen her iPad and then she accused CNA #329 of stealing the iPad. CNA #353 stated the iPad was missing maybe four or five days, then it reappeared. Interview on 03/12/25 at 11:53 A.M. with SSD #355 revealed she was in charge of keeping the facility's grievance and self-report tracking log. SSD #355 recalled someone (name not provided) had told her about the allegation and stated a CNA had taken Resident #23's meal tray which had her tablet on it and Resident #23 had thought someone had sold it to Resident #10. SSD #355 stated Resident #23 later found her tablet in Resident #10's room. When asked about the facility's grievance and self-report tracking log and the date of 01/04/25 regarding Resident #23's concern with her missing tablet, SSD #355 verified the date of 01/04/25 was accurate and was the date she was first made aware of Resident #23's missing tablet. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/25 at 12:12 P.M. the Chief Operating Officer (COO) #300 was notified the SRI and subsequent investigation regarding Resident #23's missing tablet was an insufficient investigation as it lacked resident interviews, additional staff interviews and an interview with the alleged perpetrator (CNA #329) and she did not agree or disagree. Follow-up interview on 03/12/25 at 12:19 P.M. with COO #300, the Administrator and CNA #329 revealed CNA #329 was asked questions by facility staff regarding the allegation of misappropriation, but again no record of this was available for surveyor review. CNA #329 reiterated she was not asked to complete a written witness statement as a result of the allegation. 44457 2. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including Parkinson's disease, age-related osteoporosis, dementia, generalized muscle weakness, and dependence on wheelchair. Resident #18 was hospitalized from 01/18/25 to 01/20/25. Review of a nurse's note dated 01/03/25 at 7:35 A.M. revealed Resident #18 was found on floor by nurse aide lying flat on her back. Nurse and aide picked Resident #18 up off the floor and into her wheelchair. Resident #18 was taken to the dining room for breakfast. Resident #18 stated she got up from her recliner chair to pick something up off the floor and fell backwards. It was noted Resident #18 claimed she didn't hit her head and had no complaints of pain at this time. Review of progress notes, nurse practitioner noted, and therapy notes from 01/03/25 to 01/18/25 revealed Resident #18 had complaints of pain to left hip and pelvic area. Resident #18 was medicated for pain throughout this time. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #18 had severely impaired cognition and was dependent on staff for activities of daily living (ADLs). Review of a nurse's note dated 01/18/25 at 9:55 A.M. revealed Resident #18's was sent to hospital for evaluation related to abdominal pain and suspicious x-ray of abdomen. Review of a Hospital Medicine History and Physical dated 01/18/25 revealed Resident #18 presented to hospital for concern of bowel obstruction. While in the emergency department (ED) a cat (CT) scan was completed, and Resident #18 was noted to have a fracture of the pelvis. CT results showed acute fractures of left hemipelvis involving the left superior and inferior pubic rami extending towards the medial left acetabulum. Orthopedics were following; however, the fracture was nonsurgical. Resident #18's sister was present at hospital and reported on 01/03/25 Resident #18 had a fall and had been complaining of pain to left hip since. Physical examination showed edema to right lower extremity and trace edema to left hip. Resident #18 had pain to the left hip inguinal fold area and when laying on side. Review of the Hospital Discharge Summary dated 01/20/25 revealed diagnoses including closed nondisplaced fracture of pelvis, chronic constipation, and cellulitis of extremity. (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Interview on 03/18/25 at 8:00 A.M. with Resident #18's sister revealed she had made an allegation of neglect in January 2025 and had provided videos as supporting evidence to facility staff. During the interview, the resident's sister also shared Resident #18 had a fall at the beginning of January 2025. An x-ray was completed that did not show a fracture; however, Resident #18 was in pain following the incident and was unable to advocate for herself. The resident's sister revealed around the middle of January 2025 Resident #18's stomach was hard and full for a few days and she was having edema. The sister indicated while at the hospital Resident #18 was found to have a hip fracture.

Review of a family provided one minute and 48 second video dated 01/04/25 at 7:57 A.M. revealed Resident #18 was sitting in a recliner chair for breakfast. Nurse Aide #329 was sitting in a chair next to Resident #18. Nurse Aide #329 appeared distracted during the video.

Review of a family provided two minute and three second video dated 01/04/25 at 8:00 A.M. revealed Resident #18 was sitting in recliner chair for breakfast. Nurse Aide #329 was sitting in a chair next to Resident #18. Nurse Aide #329 appeared distracted during the video and at the 15 second mark stood in the hallway before returning to sit next to Resident #18.

Review of a family provided two minute and one second video dated 01/04/25 at 9:08 A.M. revealed Resident #18 was receiving incontinence care while in bed from Nurse Aide #329 and Nurse Aide #353. Resident #18 could be heard groaning when turned by the staff. During turning at the one minute and 39 second mark Resident #18 could be heard saying ouch and says ow again at the one minute and 57 second mark while staff were attempting to re-dress the resident.

Review of a family provided one minute and 28 second video dated 01/04/25 at 11:20 A.M. revealed Resident #18 was being prepared for transfer using sit to stand lift by Nurse Aide #329 and Nurse Aide #353. At the 34 second mark Nurse Aide #329 pulls Resident #18's legs to edge of bed and the resident could be heard groaning (in pain) out loudly.

Review of a family provided two minute and two second video dated 01/04/25 at 6:07 P.M. revealed Resident #18 was in her room in wheelchair. Nurse Aide #329 and Nurse Aide #353 were observed to use sit to stand lift and take Resident #18 to bathroom.

Review of an email provided by Resident #18's sister dated 01/05/25 timed 8:35 P.M. revealed Resident #18's sister contacted the former Administrator, former DON, Social Services Designee (SSD) #355, and Ombudsman with her concerns. In the email, Resident #18's sister noted the resident fell on [DATE] and hurt her left hip and leg. The sister indicated an x-ray was taken about 6:00 P.M. on 01/03/25; however, she did not receive notification of results until 01/04/25 at 9:45 A.M. The sister indicated it was apparent Resident #18 was in pain; however, she was not made aware of a treatment plan in place. The sister stated Resident #18 was unable to request pain medications. The sister included a series of videos in the email from a camera in Resident #18's room. The sister indicated on video Nurse Aide #329 was not gentle and did not appear to be knowledgeable of Resident #18's potentially broken left hip. Sister requested Nurse Aide #329 be removed from taking care of Resident #18 due to mistreatment. Resident #18's sister also stated concerns with follow through on agreed plan of care for medications and care.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility Self-Reported Incident (SRI) dated 01/06/25 at 9:30 A.M. revealed Resident #18's sister made an allegation Nurse Aide #329 was rough during incontinence care. The resident's recent fall with pain was not included on the SRI investigation. There was no evidence of interview with Resident #18's sister nor inclusion of videos provided by sister. The facility unsubstantiated abuse. Interview on 03/18/25 at 11:33 A.M. with Admissions/Social Services Designee (SSD) #355 confirmed she had received a series of videos from Resident #18's sister. SSD #355 indicated she forwarded the email onto the interim Administrator and former Director of Nursing (DON). SSD #355 indicated she did not watch the videos she received from sister of Resident #18. Interview on 03/18/25 at 2:04 P.M. with Administrator and Chief Operating Officer (COO) #300 confirmed the videos from Resident #18's sister had been received and were not included in SRI investigation. COO #300 indicated there was nothing in the videos that appeared abusive. COO #300 confirmed information on Resident #18's fall was not included in the SRI investigation as well. Interview on 03/19/25 at 2:45 P.M. with Administrator revealed Administrator agreed to view videos submitted by sister of Resident #18. The six videos provided were reviewed. Administrator indicated it would be important to include these videos in the investigation. Administrator indicated she did not note any abuse behavior but indicated Nurse Aide #329 displayed a customer service issue. Review of facility policy Abuse Prevention dated 08/20/21 revealed once notifications of an abuse allegation were made and investigation would be conducted. The investigation should include interview with parties involved including resident, alleged perpetrator, and witnesses, expanded interviews to other residents and staff, review of resident medical records, obtain all medical reports and statements as applicable, and review employee record if they are identified as alleged perpetrator. All evidence of investigation should be documented. This deficiency represents non-compliance investigated under Complaint Number OH00162361.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure nursing assessments were completed on admission for residents. This affected one (Resident #48) of 28 residents reviewed for nursing assessments. Findings include: Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including multiple fractures of ribs, encephalopathy (condition that affects function of the brain), hallucinations and alcohol use with withdrawal. Review of Resident #48's electronic medical record and paper chart revealed there were no nursing admission assessments done when he arrived at the facility. Interview on 03/19/25 at 11:45 A.M. with the Chief Operating Officer (COO) #300 verified Resident #48 did not have a nursing assessment performed on admission to the facility on [DATE]. The facility was unable to provide a policy related to nursing assessments and timing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interviews, the facility failed to ensure the Minimum Data Set (MDS) assessments for residents were complete and accurate. This affected four (Residents #22, #24, #37 and #43) of 28 residents reviewed for the accuracy and completion of assessments. The facility census was 54. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertension and heart failure. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #22 revealed section C for cognitive patterns was not completed. Question C100 was answered yes to interview for mental status. However, questions C200, C300, C400, C500, C600, C700, C800, C900, C1000 and C1310 were all answered with either not assessed or dashes. Section J revealed question J200 was answered yes to attempt to interview the resident for pain. However, J300, J410, J520, J530 and J600 were answered not assessed or had dashes. Interview on 03/18/25 at 1:12 P.M. with the MDS Coordinator #365 revealed he completed MDS assessments offsite. He stated Social Services Director (SSD) #355 was responsible of sections C and D on the MDS assessment. He stated he was unsure why sections C was coded for an interview to be conducted and then all the questions stated not assessed. For section J, he stated he would call into the facility and speak to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) to review if the residents had pain. He stated he was not able to speak with anyone for Resident #22's pain assessment. He verified section J should have been completed. Interview on 03/18/25 at 1:59 P.M. with SSD #355 verified she answered sections C and D on MDS assessments for residents, though not always during the time frame of the MDS assessment. She verified section C was not completed for Resident #22 on his MDS dated [DATE]. 2. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including dementia, Parkinson's Disease, anxiety and hypertension. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #24 revealed section C for cognitive patterns was not completed. Question C100 was answered yes to interview for mental status. However, questions C200, C300, C400, C500, C600, C700, C800, C900, C1000 and C1310 were all answered with either not assessed or dashes. Section D revealed question D100 was answered yes to conduct a mood interview with Resident #24. However, questions D150 and D160 were answered not assessed or had dashes. Section J revealed question J200 was answered yes to attempt to interview the resident for pain. However, J300, J410, J520, J530 and J600 were answered not assessed or had dashes. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/18/25 at 1:12 P.M. with the MDS Coordinator #365 revealed he completed MDS assessments offsite. He stated SSD #355 was responsible of sections C and D on the MDS assessment. He stated he was unsure why sections C and D were coded for an interview to be conducted and then all the questions stated not assessed. For section J, he stated he would call into the facility and speak to the DON or ADON to review if the residents had pain. He stated he was not able to speak with anyone for Resident #22's pain assessment. He verified section J should have been completed. Interview on 03/18/25 at 1:59 P.M. with SSD #355 verified she answered sections C and D on MDS assessments for residents, though not always during the time frame of the MDS assessment. She verified sections C and D were not completed for Resident #22 on his MDS dated [DATE]. 3. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes mellitus, depression and chronic pain syndrome. Review of the admission MDS 3.0 assessment dated [DATE] for Resident #37 revealed section J for pain was not completed. Section J revealed question J200 was answered yes to attempt to interview the resident for pain. However, J300, J410, J520, J530 and J600 were answered not assessed or had dashes. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #37 revealed section J for pain was not completed. Section J revealed question J200 was answered yes to attempt to interview the resident for pain. However, J300, J410, J520, J530 and J600 were answered not assessed or had dashes. Interview on 03/18/25 at 1:12 P.M. with the MDS Coordinator #365 revealed he completed MDS assessments offsite. He stated for section J he would call into the facility and speak to the DON or ADON to review if the resident had pain. He stated he was not able to speak with anyone for Resident #37's pain assessment. He verified section J should have been completed. 44457 4. Review of the medical record for Resident #43 revealed an admitted [DATE] and diagnoses including sepsis, paranoid schizophrenia, moderate protein-calorie malnutrition, osteomyelitis, and traumatic arthropathy of right knee. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed an interview for mental status should be conducted with Resident #43. The brief interview for mental status (BIMS) interview was marked as not assessed on MDS section C. An interview for mood should be conducted with Resident #43. Mood interview was marked as not assessed/no information on MDS section D. Review of Medicare MDS Quarterly assessment dated [DATE] revealed Resident #43 received as needed pain medications. An interview for pain assessment should be completed for Resident #43. Pain assessment interview was marked as not assessed on MDS section J. Interview on 03/18/25 at 1:12 P.M. with MDS Coordinator #365 revealed he had worked at the facility for a year and had been completing MDS assessments offsite. MDS Coordinator #365 indicated interviews for mental status and mood were completed by Social Service Designee (SSD) #355 and the interviews for pain were completed by Assistant Director of Nursing (ADON). MDS Coordinator #365 confirmed Resident #43's MDS sections C and D for 12/31/24 assessment and section J for 01/07/25 were incomplete.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to develop and implement a baseline care plan for Resident #48. This affected one (Resident #48) out of 19 residents reviewed for baseline care plans. The facility census was 54. Findings include: Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including multiple fractures of ribs, encephalopathy (condition that affects function of your brain), hallucinations and alcohol use with withdrawal. Review of Resident #48's electronic medical record and paper chart revealed there was no baseline care plan completed after admission. Interview on 03/19/25 at 11:45 A.M. with Chief Operating Officer (COO) #300 verified Resident #48 did not have a baseline care plan completed since admission on 01/31/25. Review of the facility policy titled, Baseline Plan of Care, dated 05/01/22, revealed the interdisciplinary team, resident, resident's representative and physician would develop and implement a baseline care plan upon admission which would include the instructions needed to provide effective and person-directed care of the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to develop comprehensive care plans for residents. This affected seven (Residents #9, #22, #24, #25, #34, #48 and #49) out of 28 residents reviewed for comprehensive care plans. The facility census was 54. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertension and heart failure. Review of the care plan dated 11/12/24 for Resident #22 revealed he needed assistance with his activities of daily living (ADLs). The goal was for him to maintain his current level of functioning through the next review. Interventions were listed for ADL's including bathing, bed mobility, dressing, toilet use and personal hygiene. However, the care plan did not specify what amount of assistance Resident #22 required from staff. The care plan stated as follows: -Bathing/Showering: I require (specify what assistance) by staff with (specify bathing/showering) at least weekly and whenever I prefer. -Bed mobility: I require (specify what assistance) by staff to turn and reposition me frequently while in bed. -Dressing: I need (specify what assistance) by staff to dress me. -Personal hygiene: I need (specify) assistance from you with personal hygiene and oral care. -Toilet use: I need (specify assistance) by you for toileting. Interview on 03/18/25 at 10:09 A.M. with the Director of Nursing (DON) verified Resident #22's care plan for ADL's was not resident centered and would not provide staff with the information to care for his needs. 2. Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including multiple fractures of ribs, encephalopathy (condition that affects function of the brain), hallucinations and alcohol use with withdrawal. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #48 had impaired cognition and had depression. He used a walker and needed substantial to max assistance for toileting and showers. Review of the comprehensive care plan for Resident #48 revealed he had a care plan for his advance directives dated 03/12/25, one for his emotional, intellectual, physical and social needs dated 02/21/25 and his nutritional risks dated 02/07/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/19/25 at 11:45 A.M. with the Chief Operating Officer (COO) #300 verified Resident #48's care plan was not a comprehensive look at the resident and would not provide staff with the information to care for his needs. 3. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including heart failure, chronic respiratory failure, kidney failure, obesity and cirrhosis of the liver. Review of the care plan dated 01/31/25 for Resident #49 revealed he needed assistance with his activities of daily living (ADLs). The goal was for him to maintain his current level of functioning through the next review. Interventions were listed for ADL's including bathing, bed mobility, dressing, toilet use and personal hygiene. However, the care plan did not specify what amount of assistance Resident #22 required from staff. The care plan stated as follows: -Bathing/Showering: I require (specify what assistance) by staff with (specify bathing/showering) at least weekly and whenever I prefer. -Bed mobility: I require (specify what assistance) by staff to turn and reposition me frequently while in bed. -Dressing: I need (specify what assistance) by staff to dress me. -Personal hygiene: I need (specify) assistance ROM you with personal hygiene and oral care. -Toilet use: I need (specify assistance) by you for toileting. Interview on 03/18/25 at 10:09 A.M. with the Director of Nursing (DON) verified Resident #49's care plan for ADL's was not resident centered and would not provide staff with the information to care for his needs. 38522 4. Review of Resident #25's medical record revealed an admitted [DATE] and diagnoses including traumatic brain injury, insomnia, protein-calorie malnutrition, vascular dementia with other behavioral disturbance, anxiety and depression. Review of Resident #25's electronic medical record (EMR) revealed he had an advance directive of Do Not Resuscitate Comfort Care Arrest (DNRCCA). No care plan was available addressing Resident #25's advance directives. Interview on 03/12/25 at 9:11 A.M. with Social Service Designee (SSD) #355 revealed the MDS nurse put in the care plans, but any staff could update resident care plans. SSD #355 confirmed Resident #25 did not have a care plan developed addressing his advance directive and should have. 5. Review of Resident #34's medical record revealed an admitted [DATE] and diagnoses including vascular dementia with psychotic disturbance, paranoid personality disorder, violent behavior, osteoarthritis and depression. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #34's EMR revealed he had an advance directive of DNRCCA. No care plan was available addressing Resident #34's advance directives. Interview on 03/12/25 at 9:14 A.M. with SSD #355 revealed the MDS nurse put in the care plans, but any staff could update resident care plans. SSD #355 confirmed Resident #34 did not have a care plan developed addressing his advance directive and should have. 44457 6. Review of the medical record for Resident #9 revealed an admitted [DATE] and diagnoses including bell's palsy, systemic lupus erythematosus, congestive heart failure, hypertension, dementia, metabolic encephalopathy, malignant neoplasm of bronchus and lung, and chronic kidney disease. Review of a nurses note dated 01/11/25 revealed Resident #9 was agitated and adamant she was going home. Resident #9's son came to the facility to try to calm her down. Son reported Resident #9 was exhibiting symptoms of a urinary tract infection (UTI) as she had in the past. Hospice and Physician were notified. The physician gave an order for Ciprofloxacin (antibiotic) for seven days and to collect urine sample. Review of physician's order dated 01/12/25 revealed order for 500 milligrams (mg) Ciprofloxacin two times per day for seven days. Review of physician's order dated 01/21/25 revealed order for 100 mg Macrobid (antibiotic) two times per day for an unspecified number of days. Order was discontinued on 02/04/25. Review of the plan of care for January to March 2025 revealed no care plan related to infections was developed. Interview on 03/19/25 at 3:37 P.M. with Director of Nursing (DON) confirmed Resident #9 did not have a care plan related to infections developed. 7. Review of the medical record for Resident #24 revealed admitted [DATE] and diagnoses including dementia with psychotic disturbance, hypertension, hyperlipidemia, lymphedema, Parkinson's disease, anxiety disorder, atherosclerotic heart disease. Review of hospital discharge summary dated 11/24/24 revealed Resident #24 was admitted to hospital from 11/20/24 to 11/24/24 for cellulitis of left lower extremity. Resident #24 admitted for recurrent left lower extremity cellulitis and had previously been admitted from 11/05/24 to 11/11/24. Resident #24 was noted to have Methicillin-resistant Staphylococcus aureus (MRSA) growth on sputum culture, so Doxycycline (antibiotic) was added. Sputum culture appeared consistent with colonization. Review of Nurse Practitioner (NP) progress note dated 11/25/24 revealed Resident #24 returned from hospital on 11/24/24 with diagnosis of cellulitis. NP noted Resident #24 was discharged on antibiotic for cellulitis and MRSA in sputum culture. Review of NP progress note dated 12/16/24 revealed Resident #24 completed oral antibiotic treatment of Cephalexin for cellulitis and Doxycycline for MRSA of sputum on 12/02/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Ohio Department of Health (ODH) Ohio Disease Reporting System (ODRS) report undated revealed Resident #24 had sputum culture collected on 11/10/24 while at hospital. Results of sputum culture returned on 11/27/24 and were positive for Citrobacter koseri and Klebsiella aerogenes. Klebsiella pneumoniae carbapenemase (KPC) was detected. Review of the plan of care for March 2025 revealed no care plan related to infections or MDRO status. Interview on 03/19/25 at 3:37 P.M. with Director of Nursing (DON) confirmed Resident #24 did not have a care plan related to infections or MDRO status developed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, interview and review of the facility policy, the facility failed to timely update care plans to address changes in residents' advance directives. This affected three residents (#7, #15 and #20) out of 26 residents reviewed for care planning. Facility census was 54. Findings include: 1. Review of Resident #7's medical record revealed an admitted [DATE] and diagnoses including schizoaffective disorder, hypertension, insomnia, muscle weakness and diabetes. Review of Resident #7's electronic medical record (EMR) revealed he had an advance directive of Do Not Resuscitate Comfort Care Arrest (DNRCCA). A plan of care revised 07/05/22 revealed Resident #7 had an advance directive of full code. Review of Resident #7's paper medical record revealed he had an advance directive of full code. Interview on 03/12/25 at 9:13 A.M. with Social Service Designee (SSD) #355 revealed the Minimum Data Set (MDS) nurse put in the care plans, but any staff could update resident care plans. SSD #355 confirmed Resident #7's care plan was not revised to reflect his current advance directive of DNRCCA and should have been. 2. Review of Resident #15's medical record revealed an admitted [DATE] and diagnoses including dementia with agitation, alcohol dependence with alcohol-induced persisting dementia, generalized anxiety disorder, paranoid personality disorder and delusional disorders. Review of Individual #15's EMR revealed he had an advance directive of DNRCCA. A plan of care revised 01/02/22 revealed Resident #15 had an advance directive of full code. Review of Individual #15's paper medical record revealed he had an advance directive of full code. No signed do not resuscitate (DNR) was available in his record. Interview on 03/12/25 at 9:10 A.M. with SSD #355 revealed the MDS nurse put in the care plans, but any staff could update resident care plans. SSD #355 confirmed Resident #15's care plan was not revised to reflect his current advance directive of DNRCCA and should have been. 3. Review of Resident #20's medical record revealed an admitted [DATE] and diagnoses including type two diabetes, chronic kidney disease, traumatic brain injury, dementia with agitation and generalized anxiety disorder. Review of Individual #20's EMR revealed he had an advance directive of DNRCCA. A plan of care revised 07/23/19 revealed Resident #20 had an advance directive of full code. Review of Individual #20's paper medical record revealed he had an advance directive of full code. No signed DNR was available in his record. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/25 at 9:10 A.M. with SSD #355 revealed the MDS nurse put in the care plans, but any staff could update resident care plans. SSD #355 confirmed Resident #20's care plan was not revised to reflect his current advance directive of DNRCCA and should have been. Review of the facility policy, Baseline Plan of Care, dated 05/01/22 revealed the comprehensive plan of care will be developed within seven days after completion of the comprehensive assessment . The plan of care will be reviewed and revised by the interdisciplinary team after each MDS assessment, including both comprehensive and quarterly review assessments.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation and interview, the facility failed to ensure showers were completed for independent residents. This affected three (Residents #15, #22 and #203) of three residents reviewed who were independent with activities of daily living (ADL). The facility census was 54. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertension and heart failure. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 had clear speech, understood staff and staff understood him. There was no cognitive assessment performed on this MDS. Resident #22 was noted to be independent for showers and dressing. Review of the care plan dated 11/12/24 for Resident #22 revealed he needed assistance with his activities of daily living (ADLs). However, his care plan was incomplete and did not state the level of care he required for assistance with showers. Review of the medical record for Resident #22 from 01/01/25 through 03/10/25, revealed there was no evidence he had received showers during that period of time. Review of the shower schedule for the facility, undated, revealed Resident #22 would receive his showers on Wednesday and Saturday between 7:00 P.M. and 7:00 A.M. Interview on 03/10/25 at 10:41 A.M. with Resident #22 revealed he hadn't received his showers as scheduled and per his preference due to the shower being broken. Observation on 03/10/25 at 10:59 A.M. revealed the shower room on the west side of the building had a sign that stated the shower was broken. Interview on 03/13/25 at 8:46 A.M. with the Director of Nursing (DON) verified she was unable to find any shower sheets for Resident #22. She stated the staff document all showers on shower sheets. 2. Review of the medical record for Resident #203 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, depression and anxiety. Review of the nursing assessment and baseline care plan dated 03/04/25 revealed Resident #203 preferred to receive a shower and needed set-up help only with bathing. Review of the shower schedule for the facility, undated, revealed Resident #203 would receive his showers 7:00 P.M. to 7:00 A.M. on Wednesday and Saturday. With this schedule, Resident #203 would have received showers on 03/05/25, 03/08/25 and 03/12/25 . (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #203 from 03/04/25 through 03/13/25, revealed he refused a shower on 03/05/25. There were no other shower sheets in his record. Interview on 03/10/25 at 10:30 A.M. with Resident #203 revealed he hadn't received his showers as scheduled and per his preference since being admitted to the facility. Interview on 03/13/25 at 8:46 A.M. with the DON verified she was unable to find any other shower sheets for Resident #203. She stated the staff document all showers on shower sheets. 38522 3. Review of Resident #15's medical record revealed an admitted [DATE] and diagnoses including dementia with agitation, alcohol dependence with alcohol-induced persisting dementia, generalized anxiety disorder, paranoid personality disorder and delusional disorders. Review of a quarterly MDS 3.0 assessment dated [DATE] revealed no mental status was completed on the assessment for Resident #15. Resident #15 was independent with bathing and mobility and rejected care one to three days in the seven-day look-back period. Review of the facility shower schedule revealed Resident #15's room number was not listed on the schedule for staff to offer him showers. Review of Resident #15's nurses' notes for February 2025 and March 2025 did not record any refusals of showers. Review of Resident #15's resident tasks records revealed no shower data for the last 30 days. Interview on 03/10/25 at 12:41 P.M. with Resident #15 revealed he had not had a shower or bed bath for the last three weeks and reported the shower door room was kept locked. Interview on 03/13/25 at 8:46 A.M. with the DON verified she did not have any shower sheets to provide for Resident #15. Follow-up interview on 03/13/25 at 12:44 P.M. with the DON and Registered Nurse (RN)/Assistant Director of Nursing (ADON) #299 verified Resident #15 was not on the facility's shower schedule and should have been. Interview on 03/18/25 at 7:40 A.M. with Licensed Practical Nurse (LPN) #325 revealed some residents refused showers, but if this occurred Certified Nursing Assistants (CNAs) were to write 'refused' on the paper shower sheet and she would make a nurses' note about the refused shower as well. Interview on 03/18/25 at 8:47 A.M. with CNA #357 revealed many residents refused their showers in the facility. CNA #357 stated if this occurred, she let the nurse know and she would write refuse on a paper shower sheet for that resident, and the nurse would take the shower sheets after that. (continued on next page)

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Resident ADL Care, dated 07/01/23 the facility believed in supporting and encouraging the autonomy and independence of all residents in activities of daily living to the fullest extent possible. Residents will be expected to maintain reasonable standards of hygiene and grooming during their stay at the facility. When autonomy and independence are no longer possible or feasible, the facility resident care staff will provide the necessary support in all ADL functioning. All residents will be expected to bathe, assisted as necessary, twice per week unless otherwise specified by the physician or the resident requests more frequent bathing. This deficiency represents noncompliance investigated under Complaint Number OH00162361.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43063 Based on record review and interviews, the facility failed to ensure showers were provided as scheduled and per the resident preference for dependent residents. This affected four (Residents #23, #37, #43 and #48) of four dependent residents reviewed for activities of daily living. The facility census was 54. Findings include: 1. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes mellitus, depression and chronic pain syndrome. Review of the quarterly minimum data set (MDS) 3.0 assessment dated [DATE] for Resident #37 revealed he had intact cognition and did not refuse care. He was dependent on staff for toileting, showers, dressing and transfers. Review of the shower schedule for the facility, undated, revealed Resident #37 was scheduled for showers on Wednesdays and Saturdays from 7:00 A.M. to 7:00 P.M. for the date range of 01/01/25 through 02/25/25. On 02/26/25 his shower schedule was changed and were scheduled on Mondays and Wednesdays from 7:00 P.M. through 7:00 A.M. Review of Resident #37's electronic medical record and paper chart revealed there were no shower sheets from 01/01/25 through 02/25/25. This resulted in Resident #37 not receiving 16 showers during that time frame. Review of shower sheets from 02/26/25 through 03/11/25 revealed he was not offered a shower on 02/26/25 and 03/10/25. Interview on 03/10/25 at 10:58 A.M. with Resident #37 revealed he had not received a shower in nine months. Interview on 03/13/25 at 8:46 A.M. with the Director of Nursing (DON) verified she was unable to find any other shower sheets for Resident #37 than what she had provided as above. She stated the staff documented all showers on shower sheets. 2. Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including multiple fractures of ribs, encephalopathy (condition that affects function of the brain), hallucinations and alcohol use with withdrawal. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #48 had impaired cognition. He used a walker and needed substantial to maximum assistance for toileting and showers. Review of the shower schedule for the facility, undated, revealed Resident #48 was scheduled for showers on Wednesdays and Saturdays from 7:00 P.M. to 7:00 A.M. Review of Resident #48's electronic medical record and paper chart revealed there was one shower sheet for 03/12/25 during the time frame of 01/31/25 through 03/13/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/10/25 at 10:01 A.M. with Resident #48 revealed he had not been able to take a shower since he was admitted . He stated the shower had been broken as well. Observation on 03/10/25 at 10:59 A.M. revealed the shower room on the west side of the building had a sign that stated the shower was broken. Interview on 03/13/25 at 8:46 A.M. with the DON verified she was unable to find any other shower sheets for Resident #48 than what she had provided as above. She stated the staff documented all showers on shower sheets. 44457 3. Review of the medical record for Resident #43 revealed an admitted [DATE] and diagnoses including sepsis, paranoid schizophrenia, moderate protein-calorie malnutrition, osteomyelitis, and traumatic arthropathy of right knee. Review of Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #43 required partial/moderate assistance from staff for showering and bathing. Review of shower schedule revealed Resident #43's showers were scheduled for Mondays and Thursdays on 7:00 P.M. shift. Review of Bath/Shower Report Sheets from February 2025 to March 2025 revealed sheets for refusal on 02/20/25 for refusal on 02/23/25, for refusal on 03/03/25, for refusal on 03/06/25, for no bath given related to pain on 03/10/25, and a shower on 03/12/25. Further review of the medical record for Resident #43 revealed no evidence of additional instances of bathing offered. Interview on 03/10/25 at 2:13 P.M. with Resident #43 revealed he was unable to get assistance from staff for showering. Interview on 03/13/25 at 8:46 A.M. with Director of Nursing (DON) confirmed she was unable to locate any additional bathing documentation for Resident #43. 38522 4. Review of Resident #23's medical record revealed an admitted [DATE] and diagnoses including lumbago, low back pain, general anxiety disorder and post-traumatic stress disorder. Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had a brief interview for mental status (BIMS) score of 14 out of 15, indicating she was cognitively intact, was independent with most activities of daily living (ADLs) and required staff set up for showers/bathing. Review of the facility shower schedule revealed Resident #23 was to receive showers on night shift (7:00 P. M. to 7:00 A.M.) on Mondays and Thursdays. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #23's nurses' notes for February 2025 and March 2025 did not record any refusals of showers. Review of resident tasks records revealed no shower data for the last 30 days. There were no paper shower sheets available to review for Resident #23. Interview on 03/10/25 at 10:29 A.M. with Resident #23 reported she had not had a shower for the last two weeks, as both showers had not been working on the unit. Interview on 03/13/25 at 8:46 A.M. with the Director of Nursing (DON) verified she did not have any shower sheets to provide for Resident #23. Interview on 03/18/25 at 7:40 A.M. with Licensed Practical Nurse (LPN) #325 revealed some residents refused showers, but if this occurred Certified Nursing Assistants (CNAs) were to write 'refused' on the paper shower sheet and she would make a nurses' note about the refused shower as well. Interview on 03/18/25 at 8:47 A.M. with CNA #357 revealed many residents refused their showers in the facility. CNA #357 stated if this occurred, she let the nurse know and she would write refuse on a paper shower sheet for that resident, and the nurse would take the shower sheets after that. Review of the facility policy, Resident ADL Care, dated 07/01/23 the facility believed in supporting and encouraging the autonomy and independence of all residents in activities of daily living to the fullest extent possible. Residents will be expected to maintain reasonable standards of hygiene and grooming during their stay at the facility. When autonomy and independence are no longer possible or feasible, the facility resident care staff will provide the necessary support in all ADL functioning. All residents will be expected to bathe, assisted as necessary, twice per week unless otherwise specified by the physician or the resident requests more frequent bathing. This deficiency represents noncompliance investigated under Complaint Number OH00162361.

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44457

Based on observation, medical record review, facility policy review, Centers for Disease Control (CDC) guidance on COVID-19 and interview the facility failed to provide timely and necessary intervention following changes in resident condition.

Actual Harm occurred on [DATE] when Resident #18 had unwitnessed fall resulting in increased pain, decreased functional ability and inability to participate in therapy services due to pain. On [DATE] (15 days following the fall) Resident #18 was transferred to the hospital and assessed to have an acute fracture of left hemipelvis involving the left superior and inferior pubic rami extending towards the medial left acetabulum.

Actual Harm occurred on [DATE] when Resident #55 was admitted to the hospital for treatment of pneumonia and was experiencing dark, tarry stools. Resident #55 had tested positive for COVID-19 in the facility on [DATE] with symptoms including dry cough, nasal congestion, nausea, vomiting, and loose stools. The lack of timely and adequate medical treatment/intervention after testing positive for COVID-19 on [DATE] contributed to Resident #55's hospitalization and subsequent death on [DATE].

Actual Harm occurred on [DATE] when Resident #31 was transferred to the hospital and admitted for treatment of acute respiratory failure secondary to COVID-19. However, Resident #31 had been experiencing symptoms including nasal congestion, cough, nausea, vomiting, and loose stools since [DATE] that were not timely or adequately treated contributing to the hospitalization . During the hospitalization , Resident #31 was also noted to have pneumonia. Resident #31 was hospitalized from [DATE] to [DATE].

This affected one resident (#18) of three residents reviewed for falls/accidents and two residents (#31 and #55) of 28 residents reviewed for quality of care and treatment. The facility census was 54

Findings include:

1. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including Parkinson's disease, age-related osteoporosis, dementia, generalized muscle weakness, and dependence on wheelchair. Resident #18 was hospitalized from [DATE] to [DATE].

Review of a physician's order dated [DATE] revealed order for Acetaminophen 650 milligrams (mg) every four hours as needed.

Review of a physician's order dated [DATE] revealed order for Tramadol 50 mg every six hours as needed.

Review of a physician's order dated [DATE] revealed order for Acetaminophen 500 mg once daily for mild to moderate pain.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a nurse's note dated [DATE] at 7:35 A.M. revealed Resident #18 was found on floor by nurse aide lying flat on her back. Nurse and aide picked Resident #18 up off the floor and into her wheelchair. Resident #18 was taken to the dining room for breakfast. Resident #18 stated she got up from her recliner chair to pick something up off the floor and fell backwards. It was noted Resident #18 claimed she didn't hit her head and had no complaints of pain at this time. Review of an Orders Administration Note dated [DATE] at 5:40 P.M. revealed Resident #18 was administered as needed Acetaminophen for pain. Review of a nurse's note dated [DATE] at 6:03 P.M. revealed Resident #18 received an unspecified x-ray. Review of a Physical Therapy Summary of Daily Skilled Services note dated [DATE] at 6:43 P.M. revealed Resident #18 was noted to have had fall in morning due to ambulating on own. Unable to ensure carry over of education to wait for staff for transfers due to poor cognition. During therapy session Resident #18 was unable to use sit to stand lift or ambulate due to pain to left hip while flexing hip. Resident #18 reported moderate to severe pain. Nursing was notified. Review of Medicare Skilled Charting assessment dated [DATE] timed 6:55 P.M. revealed Resident #18 was alert and oriented to person and situation. Resident #18 had unsteady gait, impaired balance, weakness, and decreased sensation. Resident #18 required assistance for bed mobility and transfers. Resident #18 had pain to left hip/groin area status post fall and was noted to be grimacing. An x-ray was pending at time of assessment. Review of an Orders Administration Note dated [DATE] timed 9:06 P.M. revealed Resident #18 was noted to be in pain. Review of nurse's note dated [DATE] at 9:46 P.M. revealed Resident #18 complained of pain to groin and left hip to nurse. It was noted nursing staff and power of attorney (POA) argued through camera in room about Resident #18's bathing schedule. Resident #18 was noted to be upset during argument and yelled at POA. Resident #18 received a bed bath. Review of a Patient Report dated [DATE] revealed Resident #18 had one view x-ray of left hip and pelvis. X-ray showed no acute fracture or dislocation. It was noted Resident #18 had enlargement of stool within the rectal vault. Results signed by interpreting physician on [DATE] at 3:19 A.M. Review of an Orders Administration Note dated [DATE] at 9:45 A.M. revealed Resident #18 was noted to be in pain. Review of an Orders Administration Note dated [DATE] at 10:56 A.M. revealed Resident #18 was administered as needed Tramadol for hip pain. Review of an Orders Administration Note dated [DATE] at 8:26 P.M. revealed Resident #18 was administered as needed Tramadol for signs and symptoms of left hip and groin pain. Resident #18 was noted to guard areas of pain. Review of an Orders Administration Note dated [DATE] at 9:26 P.M. revealed Resident #18 was noted to be in pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE: 4360 Brecksville Rd Richfield, OH 44286	

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an Orders Administration Note dated [DATE] at 8:08 A.M. revealed Resident #18 was administered as needed Tramadol. Review of an Orders Administration Note dated [DATE] at 8:24 P.M. revealed Resident #18 was administered as needed Tramadol for complaints of generalized hip and groin pain. Review of a nurse practitioner (NP) progress note dated [DATE] revealed on [DATE] Resident #18 complained of pain to left hip with range of motion during physical therapy. Resident #18 was status post fall on [DATE]. An x-ray was ordered and completed on [DATE] with no acute abnormalities. No new orders were obtained. Review of a nurse's note dated [DATE] at 11:28 A.M. revealed nurse aide reported Resident #18 was complaining of pain to pelvic area. The NP was contacted and stated Resident #18's x-ray was negative. Review of a nurse's note dated [DATE] at 1:00 P.M. revealed nurse aide reported Resident #18 complained of pain to pelvic area. Nurse notified Director of Nursing (DON), Assistant DON (ADON), NP and POA. Review of a Pain Tool assessment dated [DATE] at 3:28 P.M. revealed Resident #18 had pain to the pelvic area. Pain was improved by Tylenol and resting and worsened by standing. Pain affected social activities, physical activities and mobility, and emotions. Review of a nurse's note dated [DATE] at 12:56 A.M. revealed Resident #18 continued to complain of left sided pelvic pain and as needed Tramadol was administered. Review of a Physical Therapy Summary of Daily Skilled Services note dated [DATE] at 5:15 P.M. revealed Resident #18 declined to participate in transfer training due to complaints of left groin pain. Nursing aware. Review of a physician's order dated [DATE] revealed order for Norco ,d+[DATE] mg twice daily for pain management for 10 days. Review of a NP progress note dated [DATE] revealed no evaluation of continued pain. The NP noted pain regimen to be Acetaminophen 500 mg daily, Acetaminophen 650 mg every four hours as needed, Tramadol 50 mg every six hours as needed, and Norco ,d+[DATE] mg twice daily. Review of a Physical Therapy Summary of Daily Skilled Services note dated [DATE] at 5:55 P.M. revealed Resident #18 complained of pain through groin during therapy and limited participation. Nursing notified of pain present during session. Review of a Physical Therapy Summary of Daily Skilled Services note dated [DATE] timed 12:48 P.M. revealed Resident #18 continued to have intermittent pain persisting to left thigh and groin. Review of a nurse's note dated [DATE] at 5:04 P.M. revealed Resident #18 received morning scheduled pain medication. During nap time Resident #18 complained of pain to nurse aide when being adjusted in bed and Resident #18 was administered as needed Tylenol. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an Orders Administration Note dated [DATE] at 8:10 A.M. revealed Resident #18 complained of pain to leg and was administered Norco. Review of a NP progress note dated [DATE] revealed no evaluation of the resident's continued pain. Review of a nurse's note dated [DATE] at 1:48 P.M. revealed nurse aide reported bilateral swelling to Resident #18's lower extremities. The NP was notified, and the diuretic Lasix was ordered as needed. Review of a NP progress note dated [DATE] revealed Resident #18 had increased edema to bilateral lower extremities. The NP ordered Furosemide (Lasix) 20 milligrams (mg) for three days and as needed. The NP noted Resident #18's bilateral lower extremities were shiny and firm. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #18 had severely impaired cognition and was dependent on staff for activities of daily living (ADLs). Review of an Orders Administration Note dated [DATE] at 7:12 P.M. revealed Resident #18 was administered an as needed suppository for constipation. Review of a Patient Report dated [DATE] revealed Resident #18 had an x-ray of the abdomen. The x-ray showed a few mildly dilated gas-filled loops of bowel, multiple non-dilated gas filled loops of bowel, and stool visualized in colon to level of hepatic flexure. Follow-up for resolution was recommended to rule out ileus or obstruction. Results signed by interpreting physician on [DATE] at 12:09 P.M. Review of a nurse's note dated [DATE] at 9:55 A.M. revealed Resident #18's abdominal x-ray results were returned. An order was received to transfer the resident to the hospital for an evaluation. Ambulance services arrived at 9:16 A.M. Review of a Hospital Medicine History and Physical dated [DATE] revealed Resident #18 presented to hospital for concern of bowel obstruction. Resident #18 had abdominal distension and stiffness. An abdominal x-ray completed prior to admission showed concern for high stool burden/obstruction. Resident #18 passed stool successfully while in hospital. While in the emergency department (ED) a cat (CT) scan was completed, and Resident #18 was noted to have a fracture of the pelvis. CT results showed acute fractures of left hemipelvis involving the left superior and inferior pubic rami extending towards the medial left acetabulum. Orthopedics were following; however, the fracture was nonsurgical. Resident #18's sister was present at hospital and reported on [DATE] Resident #18 had a fall and had been complaining of pain to left hip since. Physical examination showed edema to right lower extremity and trace edema to left hip. Resident #18 had pain to the left hip inguinal fold area and when laying on side. Review of the Hospital Discharge Summary dated [DATE] revealed diagnoses including closed nondisplaced fracture of pelvis, chronic constipation, and cellulitis of extremity. Review of a nurse's note dated [DATE] at 3:29 P.M. revealed the hospital reported Resident #18 had pelvic fracture with no surgical interventions. Resident #18 would return to facility weight bearing as tolerated. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a nurse's note dated [DATE] at 6:30 P.M. revealed Resident #18 returned to the facility from the hospital. Review of a NP progress note dated [DATE] revealed Resident #18 readmitted to facility from hospital with diagnoses of left pelvic fracture. The NP noted prior to admission Resident #18 was totally dependent on staff for ADL care needs. Review of the Medication Administration Record (MAR) for [DATE] revealed Resident #18 received as needed Acetaminophen 650 mg on [DATE] at 11:12 A.M. Resident #18 received as needed Tramadol 50 mg on [DATE] at 10:56 A.M. and 8:26 P.M., [DATE] at 8:08 A.M. and 8:24 P.M., and [DATE] at 12:56 P.M. Resident #18 received Norco ,d+[DATE] mg twice daily from [DATE] at 9:00 P.M. to [DATE] to 9:00 A.M. Resident #18 received routine Acetaminophen 500 mg once a day. Review of plan of care revised [DATE] revealed there was no care plan developed related to Resident #18's pain status. Interview on [DATE] at 8:00 A.M. with Resident #18's sister revealed she had made an allegation of neglect in [DATE] and had provided videos as supporting evidence to facility staff. During the interview, the resident's sister also shared Resident #18 had a fall at the beginning of [DATE]. An x-ray was completed that did not show a fracture; however, Resident #18 was in pain following the incident and was unable to advocate for herself. The resident's sister revealed around the middle of [DATE] Resident #18's stomach was hard and full for a few days and she was having edema. The sister indicated while at the hospital Resident #18 was found to have a hip fracture. Review of a family provided two minute and one second video dated [DATE] at 9:08 A.M. revealed Resident #18 was receiving incontinence care while in bed from Nurse Aide #329 and Nurse Aide #353. Resident #18 could be heard groaning when turned by the staff. During turning at the one minute and 39 second mark Resident #18 could be heard saying ouch and says ow again at the one minute and 57 second mark while staff were attempting to re-dress the resident. Review of a family provided one minute and 28 second video dated [DATE] at 11:20 A.M. revealed Resident #18 was being prepared for transfer using sit to stand lift by Nurse Aide #329 and Nurse Aide #353. At the 34 second mark Nurse Aide #329 pulls Resident #18's legs to edge of bed and the resident could be heard groaning (in pain) out loudly. Review of an email provided by Resident #18's sister dated [DATE] timed 8:35 P.M. revealed Resident #18's sister contacted the former Administrator, former DON, Social Services Designee (SSD) #355, and Ombudsman with her concerns. In the email, Resident #18's sister noted the resident fell on [DATE] and hurt her left hip and leg. The sister indicated an x-ray was taken about 6:00 P.M. on [DATE]; however, she did not receive notification of results until [DATE] at 9:45 A.M. The sister indicated it was apparent Resident #18 was in pain; however, she was not made aware of a treatment plan in place. The sister stated Resident #18 was unable to request pain medications. The sister included a series of videos in the email from a camera in Resident #18's room. The sister indicated on video Nurse Aide #329 was not gentle and did not appear to be knowledgeable of Resident #18's potentially broken left hip. The sister shared additional unrelated concerns related to the care of Resident #18 in the email. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a facility Self-Reported Incident (SRI) dated [DATE] at 9:30 A.M. revealed Resident #18's sister made an allegation Nurse Aide #329 was rough during incontinence care. The resident's recent fall with pain was not included on the SRI investigation. Interview on [DATE] at 11:54 A.M. with Physical Therapy Assistant (PTA) #372 confirmed Resident #18 had been complaining of pain, during walking, after her fall on [DATE]. During an interview on [DATE] at 2:04 P.M. with the Administrator and Chief Operating Officer (COO) #300, Resident #18's fall was reviewed. COO #300 indicated she was unable to remember any details of Resident #18's fall. COO #300 and the Administrator confirmed they were unable to provide any additional details related to Resident #18's fall and subsequent fracture including interventions, investigation, interdisciplinary review, or root cause analysis. Interview and review of the incident with the DON on [DATE] at 3:18 P.M. verified there was no follow-up to Resident #18's continued pain. The DON said she was not employed by the facility at the time of the incident but questioned why there wasn't another X-ray completed, since the resident was still experiencing pain. She also verified the facility was unable to locate or provide any additional information regarding the resident's fall and delay in her treatment despite concerns shared from the resident's sister and no improvement in the resident's condition. Review of facility policy Change in Condition Monitoring dated [DATE] revealed the nurse would record in the medical record information related to change in condition and notify attending physician and guardian. Review of facility policy Falls and Incident Investigation dated [DATE] revealed resident falls would be documented and investigated to determine root cause and have plan developed to prevent reoccurrence. The nurse would assess the resident and provide as needed first aide, record vital signs, initiate head injury precautions, notify supervisor, initiate incident reporting and document on incident in progress note, and notify physician and family. The DON would reassess the resident for any additional monitoring or changes to plan of care, ensure investigation occurs promptly, obtain statements from staff, and document and ensure implementation of corrective interventions. The resident would be followed on the 24-hour report and progress notes for 72 hours post-accident. The interdisciplinary team would review falls. 2. Review of the closed medical record for Resident #55 revealed an admitted [DATE] and discharge date of [DATE]. Resident #55 had diagnoses including chronic obstructive pulmonary disease, peripheral vascular disease, chronic kidney disease, dementia, and nontraumatic intracerebral hemorrhage. Review of the immunizations record revealed Resident #55 was not up to date with the COVID-19 vaccination with the last dose administered [DATE] and Resident #55 was not up to date with pneumococcal vaccinations as pneumococcal Polysaccharide Vaccine (PPSV) 23 was administered before the age of 65. Review of the physician's order dated [DATE] revealed an order for a consult to oncology for a follow up to lung mass and a repeat chest x-ray on [DATE]. Review of the nurse's note dated [DATE] revealed Resident #55 tested positive for COVID-19. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the physician's orders dated [DATE] revealed orders for contact and droplet precautions for five to 10 days if symptomatic, Dexamethasone six milligrams (mg) once daily, two to four liters of oxygen via nasal cannula to keep oxygen saturation above 92 percent, and vitals monitoring every shift. Review of the Orders Administration Note dated [DATE] revealed Resident #55 was unable to be administered Dexamethasone. Reason noted Medication not received by pharmacy. Review of the Nurse Practitioner (NP) progress note dated [DATE] revealed Resident #55 had nasal congestion. The NP ordered oxygen via nasal cannula to keep oxygen saturation above 92 percent, Dexamethasone six mg daily for seven days, and monitor temperature, pulse oximetry (ox), and respirations every shift for 10 days. The NP noted to continue Eliquis five mg twice per day, Acetaminophen 650 mg every six hours as needed, and Albuterol nebulizer every four hours as needed. Review of a physician's order dated [DATE] revealed an order for Resident #55 for a complete blood count with differential (CBC with diff) to be obtained on [DATE]. Further review of the medical record revealed no evidence the laboratory services (labs) were obtained as ordered. Review of the Orders Administration Note dated [DATE] revealed Resident #55 was unable to be administered Dexamethasone. Reason noted on order. Review of the physician's order dated [DATE] revealed Resident #55's chest x-ray was rescheduled to [DATE] due to current COVID-19 positive status. Review of the Orders Administration Note dated [DATE] revealed Resident #55 was unable to be administered Omeprazole. Reason noted was none in med cart. Review of the Orders Administration Note dated [DATE] revealed Resident #55 was unable to be administered Omeprazole. Reason noted was not available. Review of the Orders Administration Note dated [DATE] revealed Resident #55 required two liters of oxygen. Review of the Orders Administration Note dated [DATE] revealed Resident #55 had multiple episodes of diarrhea and as needed Polyethylene Glycol medication was held. Review of the NP progress note dated [DATE] revealed Resident #55 was having loose stools and nausea. The NP ordered Zofran four mg every six hours as needed. Resident #55's second finger on the right hand was noted to be discolored and cool to touch. The NP noted all fingers on the right hand were noted to be discolored and the NP contributed this to peripheral vascular disease. The NP ordered an ultrasound of the residents right upper extremity. Review of the Orders Administration Note dated [DATE] revealed Resident #55 was administered Acetaminophen for discomfort, headache and low-grade temperature of 99.1 degrees Fahrenheit (F). Review of the Orders Administration Note dated [DATE] revealed Resident #55 was administered Acetaminophen for stomach pain and Zofran for nausea and vomiting. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the NP progress note dated [DATE] revealed Resident #55 had complaints of nausea and loose stools. Stools were noted to be loose and dark tarry colored. Resident #55 reported not feeling well and not eating due to nausea and abdominal pain. Resident #55 told the nurse he was having difficulty breathing and he felt like he was dying. Resident #55 had a harsh, moist cough. The NP ordered to send Resident #55 to the emergency room for evaluation. The NP noted the ultrasound of the right upper extremity had not yet been completed. Review of the nurse's note dated [DATE] revealed Resident #55 was transported to hospital for complaints of stomach pain for a few days and black stool. Resident #55 was noted to be on a blood thinner. Review of the nurse's note dated [DATE] revealed Resident #55 was admitted to hospital for pneumonia. Review of the Ohio Department of Medicaid Facility Communication dated [DATE] revealed Resident #55 had passed away at the hospital on [DATE]. As of [DATE] the resident's death certificate was not available. Interview on [DATE] at 8:03 A.M. with the legal guardian of Resident #55 confirmed Resident #55 had passed away at the hospital. The guardian indicated she had not received the resident's death certificate yet. Additional attempts to contact the legal guardian during the survey were unsuccessful. Interview on [DATE] at 11:27 A.M. with the Administrator, COO #300, and Registered Nurse/Infection Preventionist (RN/IP) #374 revealed RN/IP #374 was not employed by the facility but had been assisting the facility with infection control in interim between IPs. Surveyor identified COVID-19 cases and Resident #55's hospitalization were reviewed with Administrator, COO #300, and RN/IP #374. The Administrator, COO #300, and RN/IP #374 were unaware of the number of COVID-19 cases that had occurred in [DATE] and were unaware Resident #55 had been hospitalized for pneumonia and subsequently passed away at hospital despite having symptoms of a change in condition since testing positive for COVID-19 on [DATE]. Interview on [DATE] at 2:13 P.M. with COO #300 revealed the facility was unable to locate evidence Resident #55 received the chest x-ray or labs as ordered. Staff present during this time period when Resident #55 experienced this change in condition were not available for interview as they either no longer worked at the facility or were agency staff. Current staff interviewed as part of the investigation including Registered Nurses (RNs) #341 and #348, Licensed Practical Nurses (LPNs) #304, #327, #369, and Certified Nurse Aides #303, #305, #326, #337, #339, #352, #353, and #357 revealed they had no knowledge of Resident #55 or the resident's change in condition that occurred from [DATE] to [DATE]. Review of facility policy Change in Condition Monitoring dated [DATE] revealed the nurse would record in the medical record information related to change in condition and notify attending physician and guardian. Review of facility policy COVID-19 Precautions and Prevention dated [DATE] revealed the facility would follow current guidelines and recommendations to ensure the facility was prepared to respond to COVID-19. A reportable outbreak was noted to be when one case had suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or three or more cases of new-onset respiratory symptoms within 72 hours. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Centers for Disease Control (CDC) guidance on COVID-19 dated [DATE] revealed COVID-19 vaccination was recommended for prevention of severe health outcomes. Several antiviral medications were recommended including Paxlovid, Remdesivir, and Lagevriol as treatment for COVID-19 to help prevent severe illness and death. 3. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including diabetes mellitus, bipolar disorder, hypothyroidism, muscle weakness, and unspecified intellectual disabilities. Resident #31 was hospitalized from [DATE] to [DATE]. Review of immunizations record revealed no evidence of Resident #31's COVID-19 or pneumococcal vaccinations status. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #31 had severely impaired cognition and was independent for activities of daily living. The assessment revealed Resident #31 was not up to date on COVID-19 vaccinations and had not received pneumococcal vaccination. Review of Nurse Practitioner (NP) progress note dated [DATE] revealed Resident #31 complained of nasal congestion and not feeling well. The NP ordered to obtain pulse oximetry (ox), respirations, and temperature every shift for four days. There was no evidence of COVID-19 testing completed and/or any other intervention to treat the resident's symptoms at that time. Review of the NP progress note dated [DATE] revealed Resident #31 continued to have nasal congestion and a cough. Resident #31 reported cough but was unable to clear anything. The NP ordered Mucinex 600 milligrams (mg) two times per day for seven days. There was no evidence of COVID-19 testing completed at this time. Review of an NP progress note dated [DATE] revealed Resident #31 complained of not feeling well and told staff He feels like he is dying. Resident #31 observed with a dry cough and nasal congestion. Resident #31 reported an episode of vomiting. The NP ordered Vitamin C 250 milligrams daily and to continue Mucinex as needed for cough. There was no evidence of COVID-19 testing completed at this time. Review of a nurse's note dated [DATE] revealed Resident #31 was experiencing a harsh, productive cough. Lung sounds were noted to be diminished. Resident #31 had four to five episodes of watery diarrhea and reported not being able to make it to the bathroom. A COVID-19 test was completed and negative. However, there was no evidence of any additional interventions being implemented at this time to treat the resident's symptoms. Review of a NP progress note dated [DATE] revealed Resident #31 had an episode of vomiting and was ordered Zofran. Resident #31 continued to have dry cough. The NP ordered a chest x-ray and laboratory services (labs). Review of a Patient Report dated [DATE] revealed Resident #31 had chest x-ray with no acute findings. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a NP progress note dated [DATE] revealed Resident #31 continued to have cough and congestion. On [DATE] Resident #31 had a chest x-ray with no findings. On [DATE] Resident #31 had four to five watery stools and was ordered Loperamide two mg every six hours as needed for diarrhea. Resident #31 also complained of nausea and emesis. Labs were ordered on [DATE] and were not obtained. Resident #31's pulse ox was 92 percent on room air and the resident's heart rate was 109 (tachycardic). There was no evidence of COVID-19 testing completed. While the NP was visiting, she was alerted Resident #31 had fallen in his room. Resident #31 was trying to walk to bathroom and became dizzy causing a fall. The NP ordered Resident #31 to be sent to the emergency room for evaluation. Review of nurse's note dated [DATE] revealed Resident #31 had been admitted to the hospital with acute hypoxic respiratory failure, pneumonia, dehydration, acute kidney injury, and was positive for COVID-19. Review of a hospital note revealed Resident #31 was admitted to the step-down unit on [DATE] for acute hypoxic respiratory failure and acute kidney injury. Resident #31 was found to have COVID-19 and pneumonia. Resident #31 had episodes of oxygen desaturation and required oxygen. Resident #31 was treated with Remdesivir, steroids and antibiotics. Remdesivir had to be stopped due to Transaminitis. Resident #31 continued to have intermittent coughing while hospitalized . Review of a NP progress note dated [DATE] revealed Resident #31 had readmitted to the facility from the hospital on [DATE]. Resident #31 was diagnosed with COVID-19, pneumonia, bilateral pulmonary embolism, left leg deep vein thrombosis, and acute kidney injury. Interview on [DATE] at 4:50 P.M. with Chief Operating Officer (COO) #300 revealed the facility was unable to locate any type of facility COVID-19 tracking log or additional information related to a COVID-19 outbreak that occurred in the facility in [DATE]. Interview on [DATE] at 11:27 A.M. with Administrator, COO #300, and Registered Nurse/Infection Preventionist (RN/IP) #374 revealed RN/IP #374 was not employed by the facility but had been assisting the facility with infection control in interim between IPs. Surveyor identified COVID-19 cases and Resident #31's hospitalization were reviewed with Administrator, COO #300, and RN/IP #374. The Administrator, COO #300, and RN/IP #374 were unaware of the number of COVID-19 cases that had occurred in [DATE] and were unaware Resident #31 had been hospitalized for treatment of COVID-19 and pneumonia after the resident had been symptomatic since [DATE]. Interview on [DATE] at 12:05 P.M. with Medical Director #366 revealed when a resident was having upper respiratory infection symptoms his first step would be to test for COVID-19. Medical Director #366 indicated if a resident was having cough and nasal congestion he would test for COVID-19. Interview on [DATE] at 2:13 P.M. with COO #300 revealed the facility was unable to locate evidence Resident #31 received labs as ordered. COO #300 confirmed Resident #31 had not been COVID-19 tested prior to [DATE] despite persisting symptoms from [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Richfield	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on [DATE] at 9:52 A.M. with Resident #31 revealed he was educated regarding the influenza and pneumococcal vaccines by the facility and he did consent to and received the vaccines, but he could not remember when he had them or when the education was. Resident #31 stated he knew he had to go to the hospital because he was sick, but he could not remember when it was, and he also could not remember any treatments or medications he was given prior to the hospitalization . He stated he had poor memory. Staff present during this time period when Resident #31 experienced this change in condition were not available for interview as they either no longer worked at the facility or were agency staff. Current staff interviewed as part of the investigation including Registered Nurses (RNs) #341 and #348, Licensed Practical Nurses (LPNs) #304, #327, #369, and Nurse Aides #303, #305, #326, #337, #339, #352, #353, and #357 revealed they had no knowledge of Resident #31 or the resident's change in condition that occurred

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	365370	A. Building B. Wing	03/31/2025

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43063

Based on observation, record review, facility policy review, and interview, the facility failed to implement an adequate and effective pressure ulcer prevention program to promote healing and to ensure Resident #49, who was cognitively impaired, dependent on staff for activity of daily living care and incontinent of bowel and bladder, received timely and necessary pressure ulcer prevent and treatment. Additionally, the facility failed to ensure accurate and comprehensive weekly skin assessments for Resident #11's in-house acquired pressure ulcer. This affected two residents (#49 and #11) of two residents reviewed for pressure ulcers. The facility census was 54.

Actual Harm occurred beginning on 01/31/25 when nursing staff failed to comprehensively assess, implement effective interventions and provide timely and necessary treatment to prevent an open area to Resident #49's coccyx/buttocks area from deteriorating to a Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcer.

Findings include:

Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including heart failure, chronic respiratory failure, kidney failure, obesity and cirrhosis of the liver.

Review of the five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 was cognitively impaired, had no behaviors, was always incontinent of bowel and bladder and was dependent on staff for toileting hygiene, rolling and transfers. There were no pressure ulcers/sores documented, however, the assessment noted the resident was at risk for developing one.

Review of the Nursing Admission Assessment with Care Plan dated 01/31/25 revealed Resident #49 was alert, was always incontinent of bowel and bladder, had skin tears to the right and left knees and was a smoker. There was no initial care plan for skin integrity or skin impairment for the resident.

Review of a nursing progress note for Resident #49 revealed on 01/31/25 at 3:00 P.M. the resident arrived at the facility with skin tears to his knees, maceration to his abdominal folds and an open area to the coccyx. The progress note did not include any additional information related to the area on the coccyx, including staging or a description of the ulcer. In addition, there was no evidence pressure ulcer prevention measures/interventions were implemented at this time.

Review of the head-to-toe assessments for Resident #49 revealed on 01/31/25 there were skin tears noted to his right and left knees.

On 02/01/25, Nurse Practitioner (NP) #363 assessed Resident #49 and documented the resident had skin issues on admission with treatments in place. There was no documentation of the actual pressure ulcers by NP #363 in the resident's nursing progress notes.

Review of the admission MDS 3.0 assessment dated [DATE] revealed the resident had no skin conditions, no pressure ulcers, no turning and repositioning program and no pressure reducing devices for the chair or bed.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The head-to-toe assessment dated [DATE] included there was a pressure ulcer to the coccyx. However, there was no description or stage of the ulcer. Review of the physician's orders for Resident #49 revealed pressure relieving interventions and wound treatments were not initiated until 02/10/25. In addition, an order dated 02/10/25 revealed head-to-toe skin check to be completed every night shift on Monday, Wednesday and Thursday was ordered. The head-to-toe assessment on 02/13/25 included there was left elbow bruising and a pressure ulcer to the coccyx. Again, there was no description or staging of the coccyx ulcer. On 02/18/25 a note at the bottom of the head-to-toe assessment revealed previously documented pressure sore to left buttock with treatment recommendations in place, no new areas noted. On 02/21/25 a note at the bottom of the head-to-toe assessment revealed impaired skin on left buttocks, previously mentioned. There was a note that included resident was non-compliant with turning and repositioning. However, no additional care plan or documentation to support the non-compliance as it pertained to the impaired skin integrity. On 02/26/25 at 7:05 P.M., nursing staff documented they did not have time to do a skin assessment during the shift. Review of a Weekly Wound Healing Record for Resident #49 dated 02/26/25 revealed the resident had a Stage III pressure ulcer to the right medial buttock that was acquired on 01/31/25 when the resident was admitted to the facility. The pressure ulcer measured 2.0 centimeters in length by 2.0 centimeters width with 0.2 centimeters depth with granulation tissue and a small amount of bloody drainage. There was odor present to the wound. Treatment was initiated with Triad Paste and the wound progress was noted to be unchanged. On 02/26/25 a treatment order was obtained for Triad Hydrophilic Wound Dress External Paste, apply to buttock topically two times a day for wound. Review of a Weekly Wound Healing Record for Resident #49 dated 03/05/25 revealed the Stage III pressure ulcer to the right medial buttock was improving. The ulcer measured 2.0 centimeters by 2.0 centimeters by 0. 1 centimeters. There was no change in treatment. On 03/07/25 pressure relieving interventions were ordered to float the heels, have a pressure reducing mattress, utilize a pressure relieving cushion to wheelchair and turning and repositioning every two hours every shift. The medication administration record and treatment administration record corresponded to these orders for Resident #49. Review of the care plan for Resident #49 dated 03/07/25 revealed the resident had potential/actual impairment to skin integrity of the right medial buttock related to fragile skin. Interventions included to encourage good nutrition and hydration, observe and document the location of skin impairment, and weekly treatment documentation to include measuring of each area of the skin breakdown's width, length, depth, type of tissue exudate and any other notable changes or observations. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/12/25 at 2:33 P.M. with NP #364 (the wound nurse) revealed she was at the facility weekly or biweekly. She stated she did not measure Resident #49's wounds and stated it was the responsibility of the facility staff to keep the measurements and document on pressure ulcers. NP #364 revealed Resident #49 had a Stage III pressure ulcer to his right medial buttock. Interview on 03/12/25 at 3:40 P.M. with the Director of Nursing (DON) verified Resident #49 had no pressure ulcers documented on his 01/31/25 head-to-toe assessment. She verified the only documentation that revealed an open area to his coccyx was on a nursing progress note on 01/31/25. The DON revealed on Resident #49's head-to-toe assessment on 02/10/25 the Stage III pressure ulcer to his coccyx was documented the first time without measurements. She stated she started at the facility on 02/17/25 and initially saw Resident #49's pressure ulcer on 02/26/25. She stated the coccyx Stage III pressure ulcer was more to the right medial buttock with measurements of 2.0 centimeters by 2.0 centimeters by 0.2 centimeters. The DON stated she was the first person to document Resident #49's Stage III pressure as the facility had not been measuring/assessing it prior. Interview on 03/17/25 at 2:29 P.M. with NP #363 revealed she was not aware the facility was not measuring any resident wounds. Interview on 03/18/25 at 10:09 A.M. with the DON verified Resident #49 did not have a wound care plan until 03/07/25 for potential interventions to his coccyx/right buttock pressure ulcer. She also verified Resident #49 did not have any wound documentation by NP #364 from 01/31/25 through 02/26/25. Observation on 03/12/25 at 2:33 P.M. of wound care to Resident #49 with NP #364 and the DON revealed the resident had a Stage III pressure ulcer measuring 1.6 centimeters by 1.0 centimeters by 0.1 centimeters. NP #364 stated the pressure ulcer was more to the right buttock than the coccyx. Review of the facility policy titled, Wound Care, dated 05/01/22 revealed it was the policy of the facility to ensure that all residents skin conditions were properly tracked and cared for. The nursing staff would assess and document the resident's significant risk factors for developing pressure ulcers as well as the nurse would document a full assessment including location, stage, length, width, depth and presence of exudates or necrotic tissue. During resident visits, the physician would evaluate and document the progress of wound healing. The physician would help the staff review and modify the care plan as appropriate, especially when wounds were not healing as anticipated or new wounds developed despite existing interventions. During monitoring, the physician would also evaluate and document the progress of the wound. 38522 2. Review of Resident #11's medical record revealed an admitted [DATE] with diagnoses including vitamin D deficiency, depression, repeated falls, dysphagia, dementia with mood disturbance and urinary and fecal incontinence. Review of Resident #11's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #11 was cognitively impaired and dependent on staff for eating, toileting, lower body dressing and required substantial/maximal staff assistance to roll left and right. Resident #11 was noted to have a Stage III pressure ulcer, not present on admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #11's physician's orders revealed an order dated 08/01/24 to admit to hospice for end-stage cerebral infarction; an order dated 11/23/24 for ProSource oral liquid (nutritional supplement) 30 milliliters (ml) by mouth twice daily; an order dated 11/24/24 for pressure reduction boots as tolerated, when in bed; an order dated 11/24/24 for air mattress; an order dated 11/26/24 for hospice to change wound dressings on Tuesday and Thursday only every night shift for wound; an order dated 11/26/24 for monitor erythema to right foot, notify physician and hospice for signs/symptoms of infection, edema or drainage and discontinue when resolved. No as-needed (PRN) wound care orders were available on Resident #11's physician's orders list. Review of an interdisciplinary team post-wound investigation summary for Resident #11 dated 11/23/24 at 10:33 (morning or evening not specified) and authored by Registered Nurse (RN) #313, who was the facility's previous DON, revealed aide (not named) informed nurse (not named) of suspected new area to the right foot. When assessed, new open areas were identified to the right shin, right lateral foot, and right pinky toe. The right foot peri-wound skin was reddened and edematous. No drainage or foul odors were noted upon assessment. Contributing factors included hospice client, limited physical activity, risk for impaired skin integrity and non-compliance with hygiene and refusals of care. Wound management completed by wound nurse practitioner, orders obtained and in place for daily treatment of wounds. Review of a weekly wound healing record-wound care nurse assessment dated [DATE] revealed Resident #11 had a facility-acquired venous ulcer to his right lateral foot measuring 3.0 centimeters (cm) length by 2.5 cm width by 0.0 cm depth with a scab noted. The assessment indicated it was the first observation of the wound, and no odor or drainage was present. Prophylactic antibiotics (Augmentin) initiated for suspected cellulitis. Cleanse the area with normal saline, pat dry. Apply calcium alginate to the wound bed. Cover with an abdominal (ABD) pad and Kerlix gauze daily and as needed. Review of the next available weekly wound healing record-wound care nurse assessment dated [DATE] revealed Resident #11 had a facility-acquired pressure ulcer to right lateral foot as of 12/18/24 that was originally a Stage III pressure ulcer and remained at that stage. The wound was unchanged, had a dry scab area and had no drainage or odor. The area measured 0 cm by 0 cm by 0 cm. Comments at the bottom indicated the wound nurse did not measure the area, leave area open to air. Treatment changed this date to Skin Prep (forms a film to protect the skin by reducing friction) to the scabbed area once daily. Review of the weekly wound healing record-wound care nurse assessment dated [DATE] revealed Resident #11 had an improving Stage III pressure area to right lateral foot. No wound measurements were included on this assessment. Review of the weekly wound healing record-wound care nurse assessment dated [DATE] revealed Resident #11 had an improving Stage III pressure area to the right lateral foot. No drainage or odor was noted. The wound measured 3.2 cm by 1.0 cm by 0.0 cm. The current treatment plan was listed as Skin Prep with ABD and Kerlix gauze change daily and PRN. Review of Resident #11's nurses' notes from November 2024 through March 2025 revealed no wound measurements. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #11's plan of care for skin/pressure areas dated 02/03/17 listed an intervention dated 11/03/19 for monitor/document/report to physician PRN changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length by width by depth) and stage. Interview on 03/11/25 at 11:48 A.M. with the DON revealed the wound nurse practitioner saw Resident #11 weekly and shared Certified Nurse practitioner (CNP) #364 told her she does not measure wounds in the facility. The DON verified she had no further wound tracking for Resident #11 as the wound started in November 2024, which was before she started her employment with the facility three weeks ago. The DON confirmed she began tracking all in-house wounds two weeks ago and indicated Resident #11's Stage III pressure ulcer on his foot was a scab and was improving. The DON verified Resident #11 did not have a PRN order for wound care in case the dressing needed to be changed in between the scheduled times and verified he should have had such an order. The DON also verified hospice completed Resident #11's wound dressing Tuesdays and Thursdays on night shift as ordered by the physician. Interview on 03/12/25 at 2:33 P.M. with CNP #364 revealed she came to the facility weekly and sometimes every other week. CNP #364 verified she did not put wound measurements in her assessments as it was the responsibility of the facility to measure the wounds. CNP #364 indicated Resident #11's Stage III pressure wound to the foot had been improving and was now a scab. Review of the facility policy, Wound Care, dated 05/01/22, revealed all residents' skin conditions would be properly tracked and cared for. The nursing staff and attending physician will assess and document and individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss and a history of pressure ulcer(s). In addition, the nurse shall describe and document/report the following: a) full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; pain assessment; resident's mobility status; current treatments including support surfaces and all active diagnoses. The staff will examine the skin of a new admission for ulcerations or alterations in skin. The physician will authorize pertinent orders related to wound treatments, including would cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agent if indicated for type of skin alteration .during resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive or non-healing wounds. The physician will help the staff review and modify the care plan as appropriate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on observation, medical record review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized fall prevention program for Resident #18 and Resident #204 to prevent falls. The facility also failed to ensure cigarette butts were properly disposed of after smoking. This affected two residents (#18 and #204) of three residents reviewed for falls/accidents and 19 residents (Residents #1, #2, #3, #9, #11, #12, #14, #16, #23, #25, #27, #29, #38, #39, #42, #43, #44, #48 and #203) identified by the facility as residents who smoke. The facility census was 54. Findings include: 1. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including Parkinson's disease, age-related osteoporosis, dementia, generalized muscle weakness, and dependence on wheelchair. Review of the st risk for falls related to deconditioning, balance problems, incontinence, intermittent aggressive behaviors, impaired safety awareness and impulse control initiated on 06/11/18 and revised on 05/13/24 revealed interventions including anticipate and meet resident's needs as able, call light reminder sign in room, custom wheelchair to allow the resident to sit upright/safely related to balance deficits; give the resident a reacher to pick up items off the floor when she drops them; locked bedside table that will remain in the side of the resident's recliner; provide a safe environment with even floors free from spills and/or clutter, adequate, glare free light, a working and reachable call light and personal items within reach. Review of the medical record revealed Resident #18 was last assessed for fall risk on 03/15/23 and was identified as at risk. Review of a physician's orders dated 02/29/24 revealed an order for a hand reacher tool at bedside for a fall intervention. Review of a physician's order dated 12/20/24 revealed an order for Dycem (non-slip self-adhesive strips) to the recliner chair. Resident #18 also had an order, dated 12/20/24 for non-skid fall strips to the floor in front of the recliner chair for safety intervention. Review of an Orders Administration Note dated 01/03/25 timed 2:09 A.M. revealed Resident #18 was having anxiety/agitation and was administered as needed Lorazepam. Review of an Orders Administration Note dated 01/03/25 timed 6:10 A.M. revealed Resident #18 was having anxiety and was administered as needed Lorazepam. However, record review revealed no evidence the resident's safety needs and/or fall risk were evaluated related to the two doses of anti-anxiety medication administered approximately four hours apart on 01/03/25. (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of a nurse's note dated 01/03/25 at 7:35 A.M. revealed Resident #18 was found on the floor by a nurse aide, lying flat on her back. Nurse and aide picked Resident #18 up off the floor and into her wheelchair. Resident #18 was taken to the dining room for breakfast. Resident #18 stated she got up from her recliner chair to pick something up off the floor and fell backwards. It was noted Resident #18 claimed she didn't hit her head and had no complaints of pain at this time.

Review of an incident report dated 01/03/25 at 7:35 A.M. revealed Resident #18 was reaching for something on the floor and fell backwards (unwitnessed). Resident #18 was educated on the importance of call before you fall. Resident #18 was noted to be wheelchair bound. Factors contributing to the fall were ambulating without assistance and gait imbalance. Resident #18's physician and power of Attorney (POA) were notified. There was no mention of the use or availability of the ordered reacher.

Review of a nurse practitioner (NP) progress note dated 01/03/25 revealed Resident #18 had a fall and was found laying on her back in room. Resident #18 was noted to be a poor historian due to cognitive and psychiatric impairments. Resident #18 told staff she stood from the recliner chair to pick something up and fell backwards. Resident #18 denied hitting her head and denied pain. Resident #18 was noted to be dependent on a wheelchair and staff to help push the wheelchair. Interventions for falls included hand reacher tool at bedside, specialized wheelchair, Dycem to recliner chair, and non-skid strips to the floor in front of the recliner.

Review of a Medicare Skilled Charting assessment dated [DATE] at 6:55 P.M. revealed Resident #18 was alert and oriented to person and situation. Resident #18 had unsteady gait, impaired balance, weakness, and decreased sensation. Resident #18 required assistance for bed mobility and transfers.

Review of a fall follow-up assessment dated [DATE] at 2:09 A.M. revealed Resident #18 had a fall on 01/03/25. An intervention was noted to keep Resident #18 in the dining room during the day.

Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #18 had severely impaired cognition and was dependent on staff for activities of daily living (ADLs).

Review of the plan of care revised 02/14/25 revealed Resident #18 was at risk for falls. Interventions included keep adaptive reacher at bed side, anticipate and meet needs as able, call light reminder sign in room, custom wheelchair, Dycem to recliner and in front of recliner, encourage non-skid footwear, encourage resident to ask for assistance with toileting and ambulation, keep call light accessible, monitor for adverse effects of medications, and provide safe environment. Resident #18 had activities of daily living (ADL) self-care performance deficit related to severe cognitive impairment. Interventions included extensive assistance of two staff for transfers with mechanical stand up lift as Resident #18 does not stand without lift. Resident #18 does not walk, and uses tilt and space wheelchair.

Further review of Resident #18's medical record revealed no evidence of routine and appropriate fall follow up or monitoring, no evidence of implemented interventions, and no evidence of review by an interdisciplinary team.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/18/25 at 2:04 P.M. Resident #18's fall was reviewed with the Administrator and Chief Operating Officer (COO) #300. COO #300 indicated she was unable to remember any details of Resident #18's fall. COO #300 and the Administrator confirmed they were unable to provide any additional details related to Resident #18's fall including interventions, investigation, interdisciplinary review, or root cause analysis. Review of facility policy Falls and Incident Investigation dated 07/22/22 revealed resident falls would be documented and investigated to determine root cause and have plan developed to prevent reoccurrence. The nurse would assess the resident and provide as needed first aide, record vital signs, initiate head injury precautions, notify supervisor, initiate incident reporting and document on incident in progress note, and notify physician and family. The DON would reassess the resident for any additional monitoring or changes to plan of care, ensure investigation occurs promptly, obtain statements from staff, and document and ensure implementation of corrective interventions. The resident would be followed on the 24-hour report and progress notes for 72 hours post-accident. The interdisciplinary team would review falls. 43063 2. Review of the medical record for Resident #204 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, hypertension, diabetes mellitus, Alzheimer's Disease and dementia. Review of the fall risk assessment dated [DATE] revealed Resident #204 was at high risk for falls. Review of the nursing admission assessment dated [DATE] for Resident #204 revealed he had a history of falls. His fall care plan stated he was at risk for falls and had a history of falls. Interventions included to ensure the call light was in reach and bed was in lowest position. Review of the nursing progress notes for Resident #204 dated from 03/03/25 through 03/11/25 revealed nursing staff had not documented him having any falls while at the facility. Observation on 03/10/25 at 2:26 P.M. of Resident #204 revealed he was on the mat on the floor beside his bed. He was repeatedly yelling for someone to help him. He was noted earlier in the shift on the mat on the floor as well. At 2:39 P.M., Licensed Practical Nurse (LPN) #362 verified Resident #204 was on the floor. With the assistance of two nurse aides, LPN #362 assisted Resident #204 back in bed. She did not perform an assessment on the resident prior to placing him back in bed. Observation on 03/11/25 at 7:12 A.M. revealed Resident #204 in bed, however, the mat was not beside the bed on the floor. At 7:52 A.M., Resident #204 was yelling out for staff and leaning towards the side of the bed towards the floor. There was no mat on the floor next to the bed. At 7:59 A.M., LPN #304 verified Resident #204 did not have a mat next to his bed as care planned for his behaviors. She stated when Resident #204 would place himself on the mat on the floor, the nursing staff would not count it as a fall. She stated they were not performing assessments on him or implementing new interventions to assist in preventing future falls as they believed it was a behavior. Interview on 03/18/25 at 10:09 A.M. with the Director of Nursing (DON) verified there were no fall investigations for Resident #204's falls out of bed. She also verified there were no interventions put into place to assist in preventing future falls of Resident #204. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Falls and Incident Investigation, dated 07/22/22, revealed all resident occurrences, whether falls or incidents, would be documented and investigated to ascertain root cause and have a plan developed to prevent reoccurrence. A fall was defined as any unexpected event that happens to a resident which results in any unintentional change in elevation. Following a fall, the nurse was to check the resident and provide first aid if needed, record vital signs, update the nursing supervisor, initiate an accident incident report, document the findings in a progress note and notify the physician and family. 3. Review of the facility document titled, Smoking List, undated, revealed 19 Residents #1, #2, #3, #9, #11, #12, #14, #16, #23, #25, #27, #29, #38, #39, #42, #43, #44, #48 and #203 who resided in the facility and smoked. Observation on 03/10/25 at 11:05 A.M. of smoking in the courtyard revealed nine (Resident #2, #3, #11, #16, #23, #27, #43, #48 and #203) residents who smoked were in the designated smoking area. Activities Director #330 was present and provided the smoking materials to the residents. The observation revealed cigarette butts were in the mulch and rocks next to the building, in plastic flower pots, wooden flower beds, on the sidewalks and in the grass areas. Resident #27 was observed to take her cigarette and put it out in the wooden flower bed that she was sitting next to. Interview on 03/10/25 at 11:05 A.M. with Activities Director #330 verified the cigarette butts on the ground, in the mulch, in the flower pots and in the wooden flower planters. She stated residents would throw their cigarettes on the ground and in the pots. She stated she attempted to clean the area everyday but residents would still continue to dispose of their cigarette butts improperly. Review of the facility policy titled, Smoking, dated 05/01/22, revealed the facility would establish and maintain safe smoking practices, allowing resident's who wished to smoke while also doing it in a safe manner.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observation and interview, the facility failed to ensure an anchoring device for Resident #204's indwelling urinary catheter was implemented to prevent catheter-related complications. This affected one resident (Resident #204) of one resident reviewed for indwelling urinary catheters. The facility census was 54. Findings include: Review of the medical record for Resident #204 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, hypertension, diabetes mellitus, Alzheimer's Disease and dementia. Review of Resident #204's physician's orders for March 2025 revealed there were no orders for an anchoring device for his urinary catheter. Review of Resident #204's baseline care plan dated 03/03/25 revealed he had a catheter care plan. Interventions included providing a leg strap for the catheter (for anchoring of the catheter). Observation on 03/10/25 at 2:26 P.M. revealed Resident #204 was on a mat on the floor beside his bed. His urinary catheter tubing was stretched tight and the drainage bag was under the mat. At 2:39 P.M. Resident #204 was still on the mat on the floor and his catheter drainage bag showed reddish-yellow urine in the drainage bag. Licensed Practical Nurse (LPN) #362 came to Resident #204's room and verified there was no anchoring device to assist in securing the urinary catheter tubing to prevent pain, potential injury or other catheter-related complications from the amount of tension on the catheter tubing due to a lack of an anchoring leg strap. Interview on 03/12/25 at 10:15 A.M. with the Director of Nursing (DON) revealed and verified the facility did not have a urinary catheter policy.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, review of the facility contract, review of the facility policy and interview, the facility failed to complete pre and post dialysis assessments as required and to collaborate care with the outside dialysis center. Also, the facility failed to ensure there was a valid contract between the facility and the outside dialysis center to ensure coordination of all care and services pertaining to dialysis treatment for Resident #25. This affected one resident (#25) of one resident reviewed for dialysis. The facility identified no other residents as receiving dialysis. The facility census was 54. Findings include: 1. Review of Resident #25's medical record revealed an admitted [DATE] and diagnoses including traumatic brain injury, insomnia, protein-calorie malnutrition, vascular dementia with other behavioral disturbance, anxiety, depression and dependence on renal dialysis. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #25 was cognitively impaired, independent with eating and required substantial/maximal assistance with toileting. The assessment indicated Resident #25 currently received hemodialysis. Review of Resident #25's plan of care dated 09/21/24 revealed Resident #25 needed hemodialysis due to renal failure and chronic kidney disease. Resident #25 went to dialysis Mondays, Wednesdays and Fridays and had listed interventions including auscultate/palpate my shunt for a thrill and bruit each shift, monitor my vital signs as ordered and notify my doctor of any significant abnormalities and observe and report if I have any signs/ symptoms of renal insufficiency, such as changes in my level of consciousness, changes in my skin turgor, mouth or changes in my heart and lung sounds. Review of Resident #25's physician's orders revealed no order specifically relating to Resident #25 receiving dialysis. In his electronic medical record (EMR) a special instruction across the top of the page read: Dialysis every Monday, Wednesday and Friday at 10:00 A.M. at Davita. A phone number was listed for Provide-A-Ride with pick up time listed as 8:45 A.M. There was an order dated 09/17/24 for checking dialysis catheter location: right chest port; an order dated 09/17/24 for post-dialysis dry weight every day shift every Monday, Wednesday and Friday for dialysis; an order dated 11/17/24 for vital signs before dialysis; and an order dated 11/17/24 for vital signs and blood glucose after dialysis. Further review of the medical record for Resident #25 revealed no evidence the facility had pre and post dialysis assessment tools being completed to contain pertinent assessment information for the resident on the tool for communication of assessment findings with the dialysis center. Interview on 03/12/25 at 2:26 P.M. with Licensed Practical Nurse (LPN) #362 revealed Resident #25 was supposed to return to the facility with a paper from the dialysis center but never did. LPN #362 indicated the facility did not have a dialysis binder with the dialysis communication sheets documenting pre and post dialysis assessments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/25 at 4:30 P.M. with LPN #304 revealed Resident #25 did not come back to the facility from dialysis with any forms or assessments. While the facility did vitals and weights before and after dialysis, the facility did not have a dialysis form or binder with communication sheets. Interview on 03/13/25 at 8:20 A.M. with LPN #325 revealed there was a dialysis form that was supposed to go with Resident #25 but the facility did not get the forms back. LPN #325 confirmed she never called the dialysis center to try to obtain the completed forms. Interview on 03/13/25 at 8:32 A.M. with the Director of Nursing (DON) verified the facility did not have any dialysis communication forms for Resident #25 and confirmed there was not an assessment piece in use at this time for dialysis residents. The DON stated there should be some kind of assessment the nurse did prior to the resident leaving to include skin, weights and vitals, the assessment would go with the resident and then the information would come back from the dialysis center to the facility with the resident. Review of the facility policy, Dialysis, reviewed 05/01/22 revealed risk factors related to potential for bleeding, alteration in fluid volume, potential for infection, alteration in fluid volume, potential for infection, psychosocial needs and risk for adverse medication effects should be identified, assessed and interventions to manage addressed in the individualized care plan. An individual care plan should be developed and followed in coordination with comprehensive assessment. A nutrition and hydration assessment should be completed and incorporated into the care plan. Arrangements should be made prior to admission for acquisition and storage of supplies, location and type of dialysis and accommodation. The policy did not identify how the facility would communicate pre and post dialysis assessment information with the dialysis center. 2. Review of the facility's dialysis transfer agreement between the facility and [NAME] Dialysis, Limited Liability Corporation (LLC) (affiliate of DaVita Incorporated) revealed it was signed by the Administrator and by the Regional Operations Director of [NAME] Dialysis, but no dates were noted on the contract or by either signature. In an interview on 03/12/25 at 3:57 P.M. the Administrator was asked regarding the date of the facility's dialysis contract. The Administrator verified the contract was effective on this date, 03/12/25, and she did not put a date as the dialysis center representative did not put a date. The Administrator confirmed a previous contract with the dialysis center from prior to 03/12/25 was unavailable for review.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on review of the personnel files, review of the facility assessment and interview, the facility failed to ensure Certified Nursing Assistants (CNAs) #305 and #329 received annual performance reviews. This affected two of two CNA's personnel files reviewed and had the potential to affect all 54 residents residing in the facility. Findings include: 1. Review of the personnel file for CNA #305 revealed there were no annual performance evaluations in her file or 12 hours of in-services as required. Interview on 03/18/25 at 3:10 P.M. with the Chief Operating Officer (COO) #300 verified CNA #305 did not have an annual performance evaluation in her personnel file. She stated the facility was unable to provide evidence of CNA #305 receiving 12 hours of in-services as required annually. Review of the facility assessment dated [DATE], revealed the facility would address areas of weakness as determined in nurse aide performance reviews during training and in-services. The facility assessment also stated training topics for staff would include communication, resident rights, abuse, infection control, culture change and dementia management. 2. Review of the personnel file for CNA #329 revealed there were no annual performance evaluations in her file or 12 hours of in-services as required. Interview on 03/18/25 at 3:10 P.M. with the Chief Operating Officer (COO) #300 verified CNA #305 did not have an annual performance evaluation in her personnel file. She stated the facility was unable to provide evidence of CNA #329 receiving 12 hours of in-services as required annually. Review of the facility assessment dated [DATE], revealed the facility would address areas of weakness as determined in nurse aide performance reviews during training and in-services. The facility assessment also stated training topics for staff would include communication, resident rights, abuse, infection control, culture change and dementia management.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observations and interviews, the facility failed to ensure staff were providing necessary behavioral health care for residents to attain and maintain their highest physical, mental and psychosocial well-being. This affected one (Resident #204) of six residents reviewed for behaviors. The facility census was 54. Findings include: Review of the medical record for Resident #204 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, hypertension, diabetes mellitus, Alzheimer's Disease and dementia. Review of the nursing admission assessment dated [DATE] for Resident #204 revealed he was alert to person only and had agitation. Review of the care plan dated 03/03/25 for Resident #204 revealed he was dependent on staff for meeting his emotional, intellectual, physical and social needs. Interventions included for staff to invite him to scheduled activities, encourage him to participate and introduce him to others with similar background and interests. He also had a care plan dated 03/03/25 due to behavioral problems related to at times rolling himself off of the bed and onto a mattress on the floor and yelling out. Interventions included for staff to anticipate and meet his needs, assist him with more appropriate methods of coping and interacting, observe his behaviors, attempt to determine the underlying causes and provide a program of activities that met his interest. Observation on 03/10/25 at 2:26 P.M. of Resident #204 revealed he was on the mat on the floor beside his bed. He was repeatedly yelling for someone to help him. He was noted earlier in the shift on the mat on the floor as well. At 2:27 P.M. Licensed Practical Nurse (LPN) #362 spoke to the resident who stated he wanted vegetable soup. LPN #362 told him they did not have vegetable soup. He then stated he would take any soup. LPN #362 stated to Resident #204 he would have to wait until dinner. At 2:39 P.M. LPN #362 verified Resident #204 was still on the floor and with the assistance of two nurse aides, the assisted Resident #204 back into bed. They did not offer Resident #204 any diversional activities or address his behaviors. Observation on 03/11/25 at 7:52 A.M. of Resident #204 revealed he was yelling out for staff and leaning towards the side of the bed towards the floor. There was no mat on the floor next to the bed. At 7:59 A.M., LPN #304 verified Resident #204 did not have a mat next to his bed as care planned for his behaviors. She stated when Resident #204 would place himself on the mat on the floor, the nursing staff would not count it as a fall. She stated they were not performing assessments on him or implementing new interventions to assist in preventing future falls as they believed it was a behavior. Observation on 03/11/25 at 12:15 P.M. revealed Resident #204 was still in bed and yelling out. Staff were not providing him with activities or diversions. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/25 at 10:40 A.M. with Certified Nursing Assistant (CNA) #305 verified staff were not getting Resident #204 out of bed. She stated due to safety concerns with kicking his legs out of the wheelchair, the staff were leaving him in bed. She was unable to state what activities or interventions they were providing to him for behaviors. Interview on 03/18/25 at 10:09 A.M. with the Director of Nursing (DON) verified staff should have been providing diversional activities for Resident #204 instead of leaving him in bed. Interview on 03/19/25 at 2:21 P.M. with the Administrator revealed staff were in-serviced on 02/20/25 related to behaviors from the facility's in-house drug/alcohol program. She was able to provide the topics of the in-service which were care of residents with drug and alcohol withdrawal as well as behaviors of verbal aggression, demanding behaviors, drug seeking, seeking a replacement for the drug and isolation. She was unable to provide other education in the previous 12 months for behaviors. The facility was unable to provide a behavioral healthcare policy and procedure. This deficiency represents non-compliance investigated under Complaint Number OH00162361.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure medications were obtained timely from the pharmacy and administered as ordered. This affected one (Resident #23) of 28 residents reviewed for medication administration. The facility census was 54. Findings include: Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including asthma, anxiety and chronic pain. Review of the physician's orders for Resident #23 revealed she had an order for Fluticasone Propionate Nasal 50 micrograms (mcg) one time a day for allergy symptoms dated 09/18/24, Hydroxyzine HCl 10 milligrams (mg) three times a day for anxiety dated 12/31/24, Cran-B-OTC Oral Liquid 30 milliliters (mL) one time a day for supplement dated 01/21/25 and Tizanidine 2 milligrams (mg) three times a day for pain dated 02/20/25. Review of the Medication Administration Record (MAR) for Resident #23 for January 2025 revealed Cran-B-OTC was not administered on 01/22/25 and 01/28/25 at 9:00 A.M. Hydroxyzine HCl 10 mg was not administered on 01/02/25 at 10:00 P.M. and at 6:00 A.M. on 01/03/25, 01/04/25, 01/08/25, 01/12/25, 01/17/25 and 01/22/25. Review of the MAR for Resident #23 for February 2025 revealed Cran-B-OTC was not administered on 02/02/25 at 9:00 A.M. Fluticasone was not administered on 02/24/25 and 02/25/25 at 9:00 A.M. as it was unavailable and on order from the pharmacy. Review of the MAR for Resident #23 for March 2025 revealed Hydroxyzine and Tizanidine were not administered on 03/06/25 at 6:00 A.M. Interview on 03/19/25 at 11:45 A.M. with the Director of Nursing (DON) verified Resident #23's medications were not given as ordered as noted above. Review of the facility policy titled, Medication Administration, dated 05/01/22, revealed medications were to be administered as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00162361.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, interview and review of the facility policy, the facility failed to act upon pharmacy reviews in a timely manner. This affected five (Residents #5, #7, #18, #24 and #37) of five residents reviewed for unnecessary medications. Facility census was 54. Findings include: 1. Review of Resident #5's medical record revealed an admitted [DATE] and diagnoses including heart failure, schizophrenia, anxiety, constipation, type two diabetes, depression and unspecified psychosis. Review of Resident #5's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she received insulin, antipsychotic's, antianxiety medications, antidepressants, anticoagulants, diuretics and opioids. Review of Resident #5's discontinued orders revealed an order dated 07/21/24 for hydroxyzine pamoate oral capsule 25 milligrams (mg) give by mouth every six hours as needed (PRN) for itching. The order was discontinued on 02/04/25. Continued review of Resident #5's discontinued orders revealed an order dated 10/11/24 for Ativan oral tablet 0.5 mg give by mouth every four hours as needed (PRN) for anxiety. The order was discontinued on 02/04/25. Review of Resident #5's assessments revealed the last Abnormal Involuntary Movement Test (AIMS) completed was on 05/24/24. Review of a pharmacy recommendation dated 09/24/24 revealed the pharmacist recommended adding a stop date to Resident #5's PRN Ativan. The recommendation was left blank and was not signed and not dated. Review of a pharmacy recommendation dated 10/23/24 revealed the pharmacist recommended adding a stop date to Resident #5's PRN Ativan and PRN hydroxyzine. The recommendation was left blank and was not signed and not dated. Review of a pharmacy recommendation dated 11/21/24 revealed the pharmacist recommended for an AIMS to be added now and every six months thereafter. The recommendation was left blank and was not signed and not dated. Nurses' notes from September 2024 through November 2024 did not indicate the pharmacy recommendations were addressed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/17/25 at 2:46 P.M. with the Director of Nursing (DON) revealed the pharmacy recommendations had not been available in the residents' medical records so she had called the pharmacy to obtain them. The DON verified Resident #5's PRN Ativan and PRN hydroxyzine medication reviews were not timely addressed as they continued without stop dates until 02/04/25. The DON also confirmed there were no additional AIMS assessments for Resident #5 to review since the one completed on 05/24/24. 2. Review of Resident #7's medical record revealed an admitted [DATE] and diagnoses including schizoaffective disorder-bipolar type, depression, generalized anxiety disorder, dementia with agitation and legal blindness. Review of Resident #7's quarterly MDS 3.0 assessment date 12/05/24 revealed Resident #7 was moderately cognitively impaired and received insulin, antianxiety medications, antidepressant medications, anticoagulants and opioids. Review of Resident #7's physician's orders revealed an order dated 09/05/24 for Xarelto 20 mg and an order dated 09/05/24 for cetirizine hydrochloride oral tablet 10 mg. Review of a pharmacy recommendation dated 05/29/24 revealed the pharmacist recommended to reduce the dose of Xarelto 20 mg to 10 mg daily. The recommendation was left blank and was not signed and not dated. Review of a pharmacy recommendation dated 05/29/24 revealed the pharmacist recommended to reduce the dose of Zyrtec 10 mg to 5 mg daily. The recommendation was left blank and was not signed and not dated. Nurses' notes from May 2024 and June 2024 did not indicate the pharmacy recommendations were addressed. Interview on 03/17/25 at 2:46 P.M. with the DON revealed the pharmacy recommendations had not been available in the residents' medical records so she had called the pharmacy to obtain them. The DON verified Resident #7's pharmacy recommendations for reducing Xarelto and Zyrtec were blank as of the time of the interview and should have been addressed timely as required. 43063 3. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including dementia with psychotic disturbance, hypertension, insomnia and anxiety. Review of the Note To Attending Physician/Prescriber, dated 09/24/24 from the pharmacist revealed Resident #24 was on Seroquel and Zyprexa (antipsychotic medications used to treat symptoms of psychosis such as delusion, hallucination, paranoia and confused thoughts) and requested the facility either document the use for two antipsychotics or adjust therapy as appropriate. The form was not addressed by the facility or the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Note To Attending Physician/Prescriber, dated 11/21/24 from the pharmacist revealed Resident #24 was on Seroquel, Risperdal and Zyprexa (antipsychotic medications used to treat symptoms of psychosis such as delusion, hallucination, paranoia and confused thoughts) and requested the facility evaluate the use of the three medications from the same drug class and adjust therapy or give clinical rationale for continued use. The form was not addressed by the facility or the physician. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #24's cognition and depression were not assessed. He was noted to be on anti-psychotics and anti-depressants. There was no gradual dose reduction attempted for the anti-psychotic medications. Review of the physician's orders for March 2025 for Resident #24 revealed he was medications including blood pressure medications, medications for insomnia, three anti-psychotic medications and an anti-depressant. Review of the care plan dated 03/10/25 for Resident #24 revealed he was on psychotropic medications (drugs that affect behavior, mood, thoughts or perceptions) related to behavior management and psychotic disturbance. Interventions included to consult with the pharmacy and his doctor to consider dosage reduction if clinically appropriate when indicated. Interview on 03/13/25 at 7:30 A.M. with the Director of Nursing (DON) verified the pharmacy recommendations for Resident #24 were not addressed by the staff or the physician for the past year. Interview on 03/17/25 at 2:46 P.M. with the DON verified the pharmacy recommendations she provided were printed off the pharmacy's website during the survey. 4. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes mellitus, depression, heart failure and bipolar disorder (mental illness that causes mood shifts between mania and depression). Review of the care plan dated 08/21/24 for Resident #37 revealed he was on psychotropic medications (drugs that affect behavior, mood, thoughts or perceptions) related to depression and bipolar disorder. Interventions included to consult with the pharmacy and his doctor to consider dosage reduction if clinically appropriate when indicated. Review of the Note To Attending Physician/Prescriber, dated 01/13/25 from the pharmacist revealed Resident #37 was on Trazadone (medication for depression) and the facility should attempt to taper the medication. If the reduction in dose was contraindicated, the physician was to document why the reduction was not indicated. The form was not addressed by the facility or the physician. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 had intact cognition and was depressed. He was noted to be on anti-psychotics, anti-depressants, insulin and hypnotic medications. There was no gradual dose reduction listed for the anti-psychotic medication. Review of the physician's orders for March 2025 for Resident #37 revealed he was on medications including insulin, blood pressure medications, medications for insomnia, anti-psychotics and anti-depressants. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/13/25 at 7:30 A.M. with the Director of Nursing (DON) verified the pharmacy recommendations for Resident #37 were not addressed by the staff or the physician for the past year. Interview on 03/17/25 at 2:46 P.M. with the DON verified the pharmacy recommendations she provided were printed off the pharmacy's website during the survey. 44457 5. Review of the medical record for Resident #18 revealed an admitted [DATE] and diagnoses including Parkinson's disease, schizophrenia, depression, dementia with severe behavioral disturbance, anxiety disorder, and depressive type schizoaffective disorder. Review of pharmacy recommendations Note to Attending Physician/Prescriber dated 09/24/24 revealed pharmacist recommended to add duration and provide supporting clinical documentation for continued use of as needed Ativan. There was no evidence of physician/prescriber response or action. The pharmacist recommended as Resident #18 was receiving Sinemet four times per day to increase Comtan from two times per day to four times per day to allow for more active Levodopa. There was no evidence of physician/prescriber response or action. Review of pharmacy recommendations Note to Attending Physician/Prescriber dated 10/24/24 revealed pharmacist recommended to attempt a dose reduction of Zoloft 50 milligrams (mg) once daily. There was no evidence of physician/prescriber response or action. Review of pharmacy recommendations Note to Attending Physician/Prescriber dated 11/22/24 revealed pharmacist recommended to add duration and provide supporting clinical documentation for continued use of as needed Ativan. There was no evidence of physician/prescriber response or action. The pharmacist recommended to evaluate 12-hour frequency on as needed Melatonin and consider change to once daily as needed. There was no evidence of physician/prescriber response or action. Review of pharmacy recommendations Note to Attending Physician/Prescriber dated 01/13/25 revealed pharmacist recommended to attempt a dose reduction of Ativan 0.5 milligrams (mg) twice daily. There was no evidence of physician/prescriber response or action. Further review of Resident #18's medical record revealed pharmacy recommendations were not addressed in a timely manner. Interview on 03/19/25 at 3:18 P.M. with Director of Nursing (DON) confirmed there had not been any evidence of physician/prescriber follow up to pharmacy recommendations. Review of facility policy Pharmacy Services Policy and Procedure dated 2025 revealed each resident shall have a drug regimen review at least monthly by a licensed pharmacist. The attending physician shall document in the resident's medical record that any medication irregularities had been reviewed and what actions were taken to address. If there were no changes to the medication the attending physician shall document rationale in the resident's medical record. Further review revealed, the facility would ensure residents who used psychotropic drugs received gradual dose reductions unless clinically contraindicated.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on interview, record review, and policy review, the facility failed to ensure residents received medications as ordered. This affected one resident (#18) of 28 residents reviewed for medications. The facility census was 54. Findings include: Review of the medical record for Resident #18 revealed an admitted [DATE] and diagnoses including Parkinson's disease, oropharyngeal phase dysphagia, schizophrenia, depression, dementia with severe behavioral disturbance, anxiety disorder, and depressive type schizoaffective disorder. Review of physician's order dated 04/22/23 revealed order for six milligrams (mg) Vraylar one time per day. The medication was scheduled for 9:00 A.M. Review of physician's order dated 12/19/23 revealed order for 0.5 mg Lorazepam two times per day. The medication was scheduled for 9:00 A.M. and 9:00 P.M. Review of physician's order dated 03/20/24 revealed order to ensure Carbidopa-Levodopa was administered one hour prior to a meal to assist with swallowing and to hold meal tray until at least 60 minutes have passed since medication administration. Review of physician's order dated 07/17/24 revealed order for 150 mg Clozaril two times per day. The medication was scheduled for 9:00 A.M. and 9:00 P.M. Review of physician's order dated 07/23/24 revealed an order for one tablet of Carbidopa-Levodopa 25-100 mg in the evening. It was noted to give medication 60 minutes prior to eating. Review of physician's order dated 08/17/24 revealed an order for two tablets of Carbidopa-Levodopa 25-100 mg before meals (three times per day). It was noted to give medication one hour prior to meals. Review of physician's order dated 10/26/24 revealed order for 75 mg Zoloft one time per day. The medication was scheduled for 9:00 A.M. Review of Medication Administration Record (MAR) for January 2025 revealed no evidence Carbidopa-Levodopa was administered at 6:00 P.M. dose on 01/04/25 and 6:00 P.M. dose on 01/14/25. Review of Medication Administration Record (MAR) for February 2025 revealed no evidence Carbidopa-Levodopa was administered at 6:30 A.M. dose on 02/04/25, 6:00 P.M. dose on 02/12/25, 6:30 A. M. dose on 02/13/25, and 6:00 P.M. dose on 02/27/25. Review of Medication Administration Record (MAR) for March 2025 revealed no evidence Carbidopa-Levodopa was administered at 6:30 A.M. dose on 03/13/25 and 6:00 P.M. dose on 03/14/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Administration History Report from February 2025 to March 2025 revealed the report indicated medication administration of Carbidopa-Levodopa had delays in treatment as follows: - 4:00 P.M. dose on 2/15/25 was not administered until 5:30 P.M. - 6:30 A.M. dose on 02/18/25 was not administered until 7:25 A.M. - 11:00 A.M. dose on 02/22/25 was not administered until 12:27 P.M. - 11:00 A.M. dose on 02/25/25 was not administered until 12:23 P.M. - 4:00 P.M. dose on 02/25/25 was not administered until 5:53 P.M. - 11:00 A.M. dose on 03/10/25 was not administered until 12:34 P.M. - 4:00 P.M. dose on 03/10/25 was not administered until 5:22 P.M. - 11:00 A.M. dose on 03/12/25 was not administered until 12:08 P.M. - 11:00 A.M. dose on 03/15/25 was not administered until 12:59 P.M. The report indicated medication administration of Clozaril, Lorazepam, Vraylar, and Zoloft had delays in treatment as follows: - 9:00 A.M. dose on 02/19/25 was not administered until 11:03 A.M. - 9:00 A.M. dose on 03/02/25 was not administered until 11:04 A.M. - 9:00 A.M. dose on 03/05/25 was not administered until 11:15 A.M. - 9:00 A.M. dose on 03/07/25 was not administered until 10:58 A.M. - 9:00 A.M. dose on 03/10/25 was not administered until 12:02 P.M. Interview on 03/10/25 at 4:19 P.M. with Resident #18's sister revealed concerns regarding timely medication pass particularly for Carbidopa Levodopa and her morning psych medications. Resident #18's sister indicated when the medications were not passed timely Resident #18 had difficulty with meals. Observation on 03/18/25 at 8:00 A.M. of Resident #18 for breakfast meal revealed Resident #18's sister had visited for breakfast and was assisting with feeding. Resident #18 was noted to have the correct diet order of puree texture with thickened liquids however Resident #18 was still noted to cough at times. Resident #18's sister indicated this was what she meant by how Resident #18 was affected by timeliness of medications. Resident #18 made few attempts to self-feed but was able to hold glass when put in hands. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/25 at 3:18 P.M. with Director of Nursing (DON) confirmed Resident #18 did not receive medications as ordered or in a timely manner for Carbidopa-Levodopa, Clozaril, Lorazepam, Vraylar, or Zoloft. Review of facility policy Medication Administration dated 05/01/22 revealed medications shall be administered in a safe and timely manner and as prescribed. Medications must be administered within one hour prior and after their prescribed time. This deficiency represents non-compliance investigated under Complaint Number OH00162361.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on observation, interview, record review and review of the facility policy, the facility failed to follow the menu spreadsheets as written to ensure proper portion sizes were served to the residents. This affected 53 residents receiving food from the kitchen as Resident #10 was ordered nothing by mouth (NPO). Facility census was 54. Findings include: Review of the facility menu corresponding to Tuesday, 03/11/25 revealed a lunch meal consisting of smothered and covered pork chop (one each), seasoned rice (four ounces), Price [NAME] vegetable blend (four ounces), yellow cake with frosting (one slice) and beverage of choice (four ounces). Review of the facility production sheet for lunch on 03/11/25 revealed those receiving a mechanical-soft diet received a #10-scoop (three ounces) of ground pork and those on a low-concentrated sweets (LCS) diet were to have a half-portion of yellow cake with frosting. Review of the facility's diet list as of 03/10/25 revealed Resident #10 was NPO, eight residents were ordered mechanical soft diets (Residents #7, #8, #16, #28, #32, #33, #35 and #204) and eight residents were ordered LCS diets (Residents #5, #20, #21, #29, #31, #36, #37 and #44). Observation on 03/11/25 starting at 11:23 A.M. revealed [NAME] #315 was taking temperatures of the foods to be served using the facility's self-calibrating electronic thermometer and putting serving utensils in each pan on the steam table. The rice was noted to have a green #12-scoop (serving 2.66 ounces) and the ground pork had a blue #16-scoop (serving two ounces). Trayline began at 11:34 A.M. Clear plastic and colored plastic bowls with cake in them were noted on the individual trays and all of the portions of cake appeared to be the same size. Interview on 03/10/25 at 10:36 A.M. with Resident #22 revealed the food at the facility was inadequate and he bought his own food because it is so bad. Interview on 03/11/25 at 11:43 P.M. with Dietary Manager (DM) #361 verified all the portions of cake for this meal were the same size. Interview on 03/11/25 at 12:09 P.M. with [NAME] #315 verified the mechanical soft pork had a #16-scoop which did not follow the spreadsheet as written. Interview on 03/11/25 at 12:15 P.M. with DM #361 verified the rice had a #12-scoop which did not follow the spreadsheet as written. During a follow-up interview on 03/11/25 at 12:40 P.M. DM #361 was made aware the facility did not follow the portion sizes for the LCS diets as a full piece of cake was provided, did not follow the portion sizes for the mechanical soft diets as too small of a scoop was used and did not follow the portion size for the rice as too small of a scoop was used and DM #361 did not disagree. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, Portion Control, no date, revealed a specific portion size shall be established for all menu items. A serving utensil that will yield the designated portion will be specified for each menu item. Review of the facility policy, Portion Sizes, no date, revealed menu items shall be served according to pre-determined portion size. The standard portion is a level measure using the appropriate serving utensil, which is used to accurately serve the designated portion size. This deficiency represents noncompliance investigated under Complaint Number OH00162361.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on observation, interview and review of the menu, the facility failed to serve palatable meals at appetizing temperatures. This had potential to affect all 53 residents receiving meals from the kitchen as Resident #10 was ordered nothing-by-mouth. The facility census was 54. Findings include: Review of the facility menu corresponding to Tuesday, 03/11/25 revealed a lunch meal consisting of smothered and covered pork chop, seasoned rice, Prince [NAME] vegetable blend, yellow cake with frosting and beverage of choice. Interview on 03/10/25 at 10:20 A.M. with Resident #48 revealed the hot food was served cold and terrible. Interview on 03/10/25 at 10:36 A.M. with Resident #22 revealed the food at the facility was inadequate and he bought his own food because it is so bad and the hot food was really cold. Interview on 03/10/25 at 1:23 P.M. with Resident #42 revealed the food at the facility was terrible as it was cold, tasted awful and was a low quality of food. Observation on 03/11/25 starting at 11:23 A.M. revealed [NAME] #315 was taking temperatures of the foods to be served using the facility's self-calibrating electronic thermometer and putting serving utensils in each pan on the steam table. Temperatures of the foods to be served were as follows: pork chop, 173 degrees Fahrenheit (F); vegetable blend, 177 degrees F; rice, 172 degrees F and cake, room temperature (not taken). Trayline began at 11:34 A.M. The east cart began at 12:09 P.M. and a test tray was requested. The test tray was made at 12:21 P.M., on the cart at 12:22 P.M., and was on the unit at 12:23 P.M. Nursing staff began passing trays from the cart immediately after its arrival. The test tray was sampled at 12:40 P.M. with Dietary Manager (DM) #361 and temperatures obtained at that time with the facility's self-calibrating electronic thermometer were as follows: pork, 116 degrees F; rice, 112 degrees F; milk, 45 degrees F; vegetable, 115 degrees F. The foods sampled were lukewarm and not palatable at the current temperatures. Interview on 03/11/25 at 12:40 P.M. with DM #361 confirmed the test tray was lukewarm and the hot foods were not at appropriate temperatures during the sampling of the test tray thus were not palatable. DM #361 stated hot foods were to be at 145 degrees F minimum at point of service. This deficiency represents noncompliance investigated under Complaint Number OH00162361.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on observation, interview, review of the facility policy and record review the facility failed to ensure foods were labeled, dated and not retained when expired. This had the potential to affect 53 residents receiving meals from the kitchen as Resident #10 was ordered nothing-by-mouth (NPO). The facility census was 54. Findings include: Observation of the kitchen on [DATE] from 9:20 A.M. to 9:54 A.M. with Dietary Manager (DM) #361 revealed the following areas of concern: In the walk-in cooler, there were two expired cartons of cream dated [DATE] and [DATE], a package of bologna that did not have a date nor a label, two expired bags of salad lettuce dated [DATE] and expired coleslaw dated [DATE]. In the dry stock room, there were nine expired cartons of thickened dairy beverage dated [DATE] that were in between rows of thickened beverages that still had appropriate dates. Interviews with DM #361 verified the above findings at the time of observation. DM #361 stated the first shift cook was responsible for checking for expired food and this was documented on the cleaning sheets. DM #361 confirmed foods were to be labeled and dated. Review of the supplied cleaning schedules revealed the morning cook was responsible for removing out-of-date items from the refrigerator at the beginning of their shift. This was not documented as completed on [DATE] and [DATE], with [DATE] being the last day this task was marked as completed. Review of the facility policy, Labeling and Dating Foods, dated [DATE] revealed to decrease the risk of foodborne illness and to provide the highest quality, foods are labeled with the date received. If the product does not have an expiration date, the product is labeled with a discard or use by date. Review of the facility policy, First In, First Out (FIFO), no date, revealed food products are used by the expiration date, if not, food items are discarded. Do not use any item that for which the manufacturers' suggested use by date has passed.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, review of facility job descriptions and interview the facility failed to ensure effective administration to manage the facility and identify care concerns, implement appropriate and sustainable corrective actions to prevent reoccurrence and attain or maintain the highest practicable physical, mental and psychosocial well being of all 54 residents residing in the facility. Findings include: 1. Review of the Administrator's job description, dated [DATE] and signed by the Administrator on [DATE], revealed the Administrator would provide overall direction for all activities related to administration, personnel, physical structure, information systems, office management and marketing of the entire facility. The Administrator works closely with all members of the management team and others to ensure their responsibilities are effectively and consistently discharged . The Administrator will ensure all facility operations are in compliance with federal, state and local regulations. The essential functions included developing and implementing facility policies and procedures that comply with federal, state and local regulations; act as liaison with the governing body, outside medical professionals, nursing staff and other professional and supervisory staff through regular meetings and periodic reporting; reports all hazardous conditions, damaged equipment and supply issues to appropriate persons; assists appropriate department heads with development and implementation of infection control procedures; and maintains the comfort, privacy and dignity of residents. Review of the Director of Nursing (DON) job description, dated [DATE] and signed by the DON on [DATE], revealed the DON played a critical role in providing superior customer service and nursing services to all residents in the facility. The DON works with the Administrator and the Medical Director in the planning, development and overall operation of the nursing department which ensures residents receive quality care 24 hours a day. The essential functions included assuring that established infection control and standard precaution practices are maintained at all times; and maintains the comfort, privacy and dignity of residents. Interview on [DATE] at 4:32 P.M. with the Administrator, DON and Chief Operating Officer (COO) #300 revealed the Administrator had assumed her position on [DATE] and the DON had assumed her position on [DATE]. During the onsite investigation, the following concerns were identified related to a lack of comprehensive and effective administrative oversight: 2. Review of the QAPI meeting minutes and sign-in sheets from [DATE] through February 2025 revealed no evidence the facility's previous Medical Director, Physician #367, attended the QAPI meetings on [DATE], [DATE], [DATE], [DATE] and [DATE]. There was no evidence a member of the facility's governing body attended the QAPI meetings until the [DATE] meeting. Additionally, there was no identification of the facility's Infection Preventionist (IP) on the sign-in sheets provided to ensure the IP was involved as required. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] starting at 3:02 P.M. interview with Chief Operating Officer (COO) #300 revealed if the medical director attended by phone or in person, their attendance should have been reflected on the QAPI signature sheets. COO #300 was made aware during the interview there was no evidence Physician #367 had attended any of the QAPI meetings before Physician #366 took over the Medical Director role in [DATE]. COO #300 verified there were no QAPI meeting minutes or sign-in sheets for [DATE] and [DATE] available for review. 3. Observations of the facility on [DATE] revealed loose hand-rails, broken blinds, discolored ceiling tiles, dented and chipped walls and a broken shower room. Interview on [DATE] at 1:00 P.M. with the Administrator verified the observed findings and shared the facility did not have a maintenance director as of the time of the interview. 4. Continued observations of the facility on [DATE] revealed hot water temperatures across the facility ranged from 77 degrees Fahrenheit (F) to 102.6 degrees F which did not provide the residents with a comfortable, homelike environment. Interview on [DATE] at 11:42 A.M. with Housekeeping Director (HD) #306 verified the observed findings, indicated this was the first time he had checked water temperatures and had no record of water temperatures being checked previously. 5. Review of the facility's infection control program documentation revealed a lack of a legionella water management program and an incomplete infection tracking and trending log including antibiotic use and COVID-19. There was no documentation to show there had been a routine and consistent infection preventionist at the facility in the time leading up to the survey. Documentation indicated concerns were identified with offering and providing influenza, COVID-19 and pneumonia vaccines as required. Additionally, the facility did not collaborate timely with the local health department regarding residents with suspected Carbapenem-Resistant Enterobacterales (CRE) infections and did not identify or place residents in Enhanced Barrier Precautions (EBP) as indicated per the Centers for Disease Prevention and Control (CDC). Interviews with administrative staff, including the Administrator, DON and COO #300 during the survey period verified the infection control concerns identified during the survey. 6. Review of QAPI meeting minutes revealed for the month of [DATE] (date not specified) there was an action plan to a (unidentified date) state agency survey with citations for dignity, not providing private communication, quality of care, notification of condition change, homelike environment, reporting allegations of abuse, investigating allegations of abuse, assistance with activities of daily living, activities to meet the needs of the residents, accidents/hazards, nutrition, significant medication errors, medication storage, notification of laboratory results and infection control. The plan referenced to see the plan of correction and indicated the department responsible for the corrective action. The columns under completion date and follow-up were blank. There was no additional information provided to verify the correction plan was completed. During the current annual survey, repeat deficiencies were identified related to privacy, homelike environment, reporting abuse to the state agency, investigating allegations of abuse, activities of daily living assistance, quality of care, falls, significant medication errors and infection control in addition to additional citations due to a lack of oversight and monitoring. (continued on next page)

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 03/31/2025
NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Review of the [DATE] QAPI meeting minutes included an action plan related to a survey (not identified) with citations for food storage and appropriate garbage disposal. Under tasks, the minutes directed to see plan of correction (POC). Departments were assigned, completion dates were indicated as ongoing and no follow-up was identified. There was no evidence corrective actions or a PIP were completed. During the annual survey, concerns were identified related to expired and undated foods. 8. Review of the second set of [DATE] QAPI meeting minutes included an action plan to address missing copies of Do Not Resuscitate (DNR) forms, also known as advance directives. Tasks were listed and staff were assigned. The columns under completion date and follow up were blank and there was no evidence corrective actions or a PIP were completed. During the annual survey, concerns were identified related to advance directives. 9. Review of the [DATE] QAPI meeting minutes included an action plan related to a survey (not identified) with citations related to dignity, reporting allegations of abuse to the state survey agency, thoroughly investigating allegations of abuse, bowel and bladder concerns, nutrition, significant medication errors and safe, homelike environment. Under tasks, the minutes directed to see plan of correction (POC). Staff were assigned, completion dates were indicated as ongoing and no follow-up was identified. There was no evidence corrective actions or a PIP were completed. During the annual survey, concerns were identified in some of the identified areas including reporting alleged abuse to the state survey agency, thoroughly investigating allegations of abuse, bowel and bladder, significant medication errors and a safe, homelike environment. 10. Review of the [DATE] QAPI meeting minutes included an action plan to address an in-house acquired pressure ulcer, affecting Resident #11. Tasks were listed and staff were assigned. The columns under completion date and follow up were blank and there was no evidence corrective actions or a PIP were completed. During the annual survey, concerns were identified related to pressure ulcers. Resident #11, the resident with the identified in-house acquired pressure ulcer found on [DATE], had a task including weekly measurements of all areas input into the Electronic Medical Record (EMR) no longer than seven days apart. Record review and interview indicated Resident #11's wound was not measured again until [DATE]. A deficiency was issued regarding pressure ulcers during the annual survey. 11. The February 2025 QAPI meeting minutes revealed an environmental PIP was started on [DATE] with weekly updates on the program documented in the minutes. During the annual survey, concerns were identified related to the environment and deficiencies were issued. Interview on [DATE] at 4:32 P.M. with Chief Operating Officer (COO) #300 revealed she relied on the facility's DON and the Administrator to follow up with any QAPI-related concerns. The COO verified she was unaware the PIPs were not completed prior to the interview.

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review and interview, the facility failed to ensure the facility assessment was accurately completed. The facility also did not implement their facility assessment in regard to staff training and education. This had the potential to affect all 54 residents residing at the facility. Findings include: 1. Review of the letter dated 05/25/23 from the state survey agency to the facility revealed the facility had their request approved to decrease the capacity and licensed beds to 72 residents. Review of the facility assessment dated [DATE] revealed the resident profile portion was incorrect. The number of residents the facility was licensed to care for stated 118. Their average daily census ranged from 35 to 85 residents (the capacity for the facility was 72 as of 05/25/23). On 03/17/25 at 12:05 P.M. interview with the Administrator verified the facility assessment was inaccurate and did not reflect the correct capacity. 2. Review of in-services provided by the facility from 05/13/24 through 02/20/25 revealed staff had received eight trainings total and the topics included abuse, human resource issues, answering call lights, infection prevention, documentation, supplies, communication, resident smoking, harassment free working conditions, mechanical lift policy, transfers, therapy, dementia care, stepping stones program (drug and alcohol program), customer service, hydration and calling off to the facility. In-service sheets revealed not all employees were present at the eight trainings and had not received all the trainings listed above. Review of the facility assessment dated [DATE] revealed the facility would address areas of weakness as determined in nurse aide performance reviews during training and in-services. The facility assessment stated training topics for staff would include communication, resident rights, abuse, infection control, culture change and dementia management. Review of the personnel file for Certified Nursing Assistant (CNA) #305 revealed a hire date of 06/03/21 and no evidence the CNA had received 12 hours of in-services annually (March 2024 24 through March 2025) nor had they received their annual performance evaluations to address areas of weakness during training and in-services. No evaluation was located for 2024. Review of the personnel file for CNA #329 revealed a hire date of 03/04/05 and no evidence the CNA had received 12 hours of in-services annually (March 2024 24 through March 2025) nor had they received their annual performance evaluations to address areas of weakness during training and in-services. No evaluation was located for 2024. Interview on 03/18/25 at 3:10 P.M. with the Chief Operating Officer (COO) #300 verified CNA #305 and CNA #329 did not receive 12 hours of in-services as required annually or their annual performance evaluations as indicated in the facility assessment. (continued on next page)

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	365370	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Richfield	4360 Brecksville Rd Richfield, OH 44286

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/19/25 at 2:21 P.M. with the Administrator verified she was unable to locate any other in-services or education for staff from March 2024 through March 2025.

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F 0841

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.

38522

Based on record review, contract review, review of the facility policy and staff interview, the facility failed to ensure the medical director fulfilled his responsibilities related to the coordination of medical care, the implementation of facility policies and procedures and evidence of participation in Quality Assurance and Performance Improvement to ensure quality care is provided to residents. This affected all 54 residents who reside in the facility.

Findings include:

Review of available Medical Director reports from January 2024 through February 2025 revealed one report from February 2025. The report indicated the environment was clean and hazard free and residents appeared to be clean and comfortable with safety measures in place. There were no documented concerns relating to pressure areas, falls or changes in condition.

During an interview on 03/17/25 at 12:05 P.M., Medical Director #366 stated he had been the facility's Medical Director since 07/01/24. Medical Director #366 did not voice concerns relating to effective administration of the facility or indicate any areas that needed to be addressed by the facility to ensure they provided appropriate care and services to the residents.

Interview on 03/19/25 at 1:12 P.M. with Chief Operating Officer (COO) #300 verified the only Medical Director report available from the last 12 months was from February 2025. COO #300 stated the previous Director of Nursing did not keep this kind of documentation and should have.

Review of a medical director agreement with Physician #366 dated 06/10/24 revealed the Medical Director was to assist the facility in meeting the applicable standards established under state and federal law. The Medical Director shall be responsible for the implementation of policies related to the care of residents at the facility and for the coordination of medical care at the facility and was responsible for assisting the facility to provide appropriate care, both medical and clinical, to residents. The Medical Director shall monitor and ensure the implementation of resident care policies and provide oversight and supervision of the nursing, medical care and physician services rendered to residents of facility with respect to the implementation of policies related to care of residents at facility, physician shall be responsible for assisting in implementing policies related to admission, transfers/discharges, infection control, the use of restraints, physician privileges/practices, non-physician health care workers, accidents and incidents, ancillary services, use of medication, use/release of clinical information, patient rights, utilization review and any other policies related to the quality of care at facility as deemed necessary by facility and/or required by applicable law or regulation.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, Medical Director Policy and Procedure, dated 2025 revealed the medical director shall be responsible for the implementation of the coordination of the medical care in the facility. The medical director shall be responsible for the following areas of care/services: implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications; participation in the quality assessment and assurance (QAA) committee; addressing issues related to the coordination of medical care and implementation of resident care policies identified through the facility's QAA committee and other activities and active involvement in the process of conducting the facility assessment. Additional medical responsibilities include but are not limited to administrative decisions, quality of care, professional development, infection control, establishing policies, resident self-determination, identifying expectations and facilitating feedback an medical care intervention and oversight.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on record review, observations and interviews, the facility failed to ensure medical records were complete and accurate. This affected four (Residents #11, #18, #22 and #43) of 28 records reviewed. The facility census was 54. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including dementia with behavioral disturbance and Coronavirus Disease 2019 (COVID-19). Review of the physician's orders for Resident #11 revealed an order dated 12/27/24 to maintain contact and droplet precautions every shift. Review of the Treatment Administration Record (TAR) for March 2025 for Resident #11 revealed nursing staff were still signing that Resident #11 was on contact and droplet precautions for COVID-19. Observation and interview on 03/10/25 at 11:46 A.M. with Certified Nursing Assistant (CNA) #305 verified Resident #11 was on enhanced barrier precautions related to having a wound. She stated staff wore gowns and gloves when providing care. Interview on 03/18/24 at 10:09 A.M. with the Director of Nursing (DON) verified Resident #11 should not have the physician's order for contact/droplet precautions as he no longer had COVID-19. She stated the order should have been discontinued in January 2025. 2. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertension and heart failure. Review of the physician's orders for Resident #22 revealed an order dated 12/28/24 to maintain contact and droplet precautions every shift for 5 to 10 days if symptomatic. Review of the Treatment Administration Record (TAR) for March 2025 for Resident #22 revealed nursing staff were still signing that Resident #22 was on contact and droplet precautions for COVID-19. Interview on 03/13/25 at 12:25 P.M. with Resident #22 verified he had COVID-19 in December of 2024. He verified he was not on isolation for COVID-19. Interview on 03/18/24 at 10:09 A.M. with the Director of Nursing (DON) verified Resident #22 should not have the physician's order for contact/droplet precautions as he no longer had COVID-19. She stated the order should have been discontinued in January 2025. 44457 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #18 revealed an admitted [DATE] and diagnoses including Parkinson's disease, oropharyngeal phase dysphagia, schizophrenia, depression, dementia with severe behavioral disturbance, anxiety disorder, and depressive type schizoaffective disorder. Review of nurses note dated 12/27/24 revealed Resident #18 had tested positive for COVID-19. Review of physician's order dated 12/30/24 revealed an order to maintain contact and droplet precautions. There was no noted duration on the order. Review of the Treatment Administration Records (TAR) from January 2025 to March 2025 revealed nursing staff continued to signed off on confirmation of contact and droplet precautions through 03/17/25. Observations from 03/10/25 to 03/20/25 revealed no evidence Resident #18 was on any kind of transmission based precautions. Interview on 03/18/25 10:09 A.M. with Director of Nursing (DON) confirmed Resident #18 still had an order for contact/droplet precautions that needed discontinued due to resolved symptoms. The DON indicated she noticed the orders in place that were no longer applicable when she was doing medication pass. 4. Review of the medical record for Resident #43 revealed an admitted [DATE] and diagnoses including COVID-19 (12/28/24), sepsis, anemia, diabetes mellitus, paranoid schizophrenia, and chronic obstructive pulmonary disease. Review of nurses note dated 12/27/24 revealed Resident #43 had tested positive for COVID-19. Review of physician's order dated 12/30/24 revealed an order to maintain contact and droplet precautions. There was no noted duration on the order. Review of Treatment Administration Records (TAR) from January 2025 to March 2025 revealed nursing staff continued to sign off on confirmation of contact and droplet precautions through 03/17/25. Observations from 03/10/25 to 03/20/25 revealed Resident #43 was on enhanced barrier precautions for a wound. Interview on 03/18/25 10:09 A.M. with the Director of Nursing (DON) confirmed Resident #43 still had an order for contact/droplet precautions that needed discontinued due to resolved symptoms. The DON indicated she noticed the orders in place that were no longer applicable when she was doing medication pass.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on record review, facility policy and procedure review and interview the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) committee that identified concerns timely and effectively. This had the potential to affect all 54 residents in the facility. Findings include: Review of the facility QAPI minutes and Performance Improvement Plan (PIP) documentation revealed the following plans without continued corrective action, evidence the plan was revised when necessary or changed once identified to be ineffective: 1. Review of QAPI meeting minutes revealed for the month of [DATE] (date not specified) there was an action plan to a (unidentified date) state agency survey with citations for dignity, not providing private communication, quality of care, notification of condition change, homelike environment, reporting allegations of abuse, investigating allegations of abuse, assistance with activities of daily living, activities to meet the needs of the residents, accidents/hazards, nutrition, significant medication errors, medication storage, notification of laboratory results and infection control. The plan referenced to see the plan of correction and indicated the department responsible for the corrective action. The columns under completion date and follow-up were blank. There was no additional information provided to verify the correction plan was completed. During the current annual survey, repeat deficiencies were identified related to privacy, homelike environment, reporting abuse to the state agency, investigating allegations of abuse, activities of daily living assistance, quality of care, falls, significant medication errors and infection control in addition to additional citations due to a lack of oversight and monitoring. 2. Review of the [DATE] QAPI meeting minutes included an action plan related to a survey (not identified) with citations for food storage and appropriate garbage disposal. Under tasks, the minutes directed to see plan of correction (POC). Departments were assigned, completion dates were indicated as ongoing and no follow-up was identified. There was no evidence corrective actions or a PIP were completed. During the annual survey, concerns were identified related to expired and undated foods. 3. Review of the second set of [DATE] QAPI meeting minutes included an action plan to address missing copies of Do Not Resuscitate (DNR) forms, also known as advance directives. Tasks were listed and staff were assigned. The columns under completion date and follow up were blank and there was no evidence corrective actions or a PIP were completed. During the annual survey, concerns were identified related to advance directives. (continued on next page)

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F 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

4. Review of the [DATE] QAPI meeting minutes included an action plan related to a survey (not identified) with citations related to dignity, reporting allegations of abuse to the state survey agency, thoroughly investigating allegations of abuse, bowel and bladder concerns, nutrition, significant medication errors and safe, homelike environment. Under tasks, the minutes directed to see plan of correction (POC). Staff were assigned, completion dates were indicated as ongoing and no follow-up was identified. There was no evidence corrective actions or a PIP were completed.

During the annual survey, concerns were identified in some of the identified areas including reporting alleged abuse to the state survey agency, thoroughly investigating allegations of abuse, bowel and bladder, significant medication errors and a safe, homelike environment.

5. Review of the [DATE] QAPI meeting minutes included an action plan to address an in-house acquired pressure ulcer, affecting Resident #11. Tasks were listed and staff were assigned. The columns under completion date and follow up were blank and there was no evidence corrective actions or a PIP were completed.

During the annual survey, concerns were identified related to pressure ulcers. Resident #11, the resident with the identified in-house acquired pressure ulcer found on [DATE], had a task including weekly measurements of all areas input into the Electronic Medical Record (EMR) no longer than seven days apart. Record review and interview indicated Resident #11's wound was not measured again until [DATE]. A deficiency was issued regarding pressure ulcers during the annual survey.

6. The February 2025 QAPI meeting minutes revealed an environmental PIP was started on [DATE] with weekly updates on the program documented in the minutes.

During the annual survey, concerns were identified related to the environment and deficiencies were issued.

Interview on [DATE] at 4:32 P.M. with the Administrator, Director of Nursing (DON) and Chief Operating Officer (COO) #300 revealed QAPI was a mechanism in place to use the support of the interdisciplinary team to identify and resolve issues. The facility preferred to meet monthly for QAPI instead of just quarterly, as well as any time there was a problem. The Administrator indicated if there was a self-reported incident (SRI) or if there was an outbreak of an illness, such as COVID-19 the facility could hold an ad hoc (not planned) QAPI meeting. Staff verified there was not an ad hoc QAPI meeting during [DATE] when the facility had an outbreak of COVID-19 but stated there should have been. During the interview, COO #300 was made aware none of the QAPI meeting minutes provided prior to February 2025 did not have a full PIP developed, evidence of auditing, education or other corrective measures completed to address the facility identified concerns or for ongoing monitoring to prevent reoccurrence. COO #300 was not aware of this prior to the interview and stated she relied on the facility's DON and the Administrator to follow up with any QAPI-related concerns. Staff verified the facility had one PIP in place for the environment but verified the hot water temperatures were not identified as part of the environmental issues leading to the development of their PIP. The Administrator verified as of the time of the interview, there was not yet a mechanism in place for residents and staff to report issues to the facility's QAPI program.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, Quality Assurance and Performance Improvement (QAPI) Policy and Procedure, dated 2025 revealed the facility implemented a comprehensive QAPI program which addresses all the care and unique services that the facility provides. To ensure continuous evaluation of the facility's systems the facility would ensure care delivery systems function consistently, accurately and incorporate current and evidence-based practice standards where available; preventing deviation from care processes, to the extent possible; identifying issues and concerns with the facility's systems as well as identifying opportunities for improvement; and developing and implementing plans to correct and/or improve identified areas. The facility would develop, implement and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility would develop and implement systems that ensure the care and services it delivers meet acceptable standards of quality in accordance with recognized standard of practice. The facility shall maintain proper documentation of its QAPI program and provide evidence of its ongoing QAPI program.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 38522 Based on record review, interview and review of the facility policy, the facility failed to ensure all required members of the quality assurance performance improvement (QAPI) committee met quarterly as required. This affected all 54 residents residing in the facility. Findings include: Review of the QAPI meeting minutes and sign-in sheets from January 2024 through February 2025 revealed QAPI met on 03/19/24, 04/16/24, 05/21/24, 06/18/24, 07/16/24, 08/16/24, 09/17/24, 10/15/24, January 2025 and February 2025. There was no evidence the facility's previous Medical Director, Physician #367, attended the QAPI meetings on 03/19/24, 04/16/24, 05/21/24, 06/18/24 and 07/16/24. There was no evidence a member of the facility's governing body attended the QAPI meetings until the January 2025 meeting. Additionally, there was no identification of the facility's Infection Preventionist (IP) on the sign-in sheets provided to ensure the IP was involved as required. On 03/17/25 at 12:05 P.M. telephone interview with Physician #366 revealed he had been the Medical Director at the facility since 07/01/24. Physician #366 stated the facility had QAPI meetings monthly which he strove to attend and denied any concerns with the facility at this time. On 03/17/25 starting at 3:02 P.M. interview with Chief Operating Officer (COO) #300 revealed if the medical director attended by phone or in person, their attendance should have been reflected on the QAPI signature sheets. COO #300 was made aware during the interview there was no evidence Physician #367 had attended any of the QAPI meetings before Physician #366 took over the Medical Director role in July 2024. COO #300 verified there were no QAPI meeting minutes or sign-in sheets for November 2024 and December 2024 available for review. Follow-up interview on 03/19/25 at 2:28 P.M. with COO #300 confirmed she was unable to provide IP certificates for the former Assistant Director of Nursing (ADON) or the night nurse (not identified) that helped to cover the IP 'role for a time.' COO #300 confirmed she only covered the facility's infection control program for January 2025 and February 2025 and attended the facility's QAPI meetings those months and verified there was no evidence the IP routinely attended QAPI meetings as required. Review of the facility policy, QAPI Committee Meetings, dated 05/01/22 revealed the facility's Quality Assurance (QA)/Quality Improvement (QI) committee members include but are not limited to: Director of Nursing, Medical Director/Physician, Administrator, Director of Housekeeping/Laundry, Director of Therapeutic Recreation, Director of Social Work, Director of Food Services, Director of Rehabilitation, QA Nurse, Director of Maintenance and Other designated facility staff. The policy did not identify the IP role as a required component of its QA/QI meetings. The QA/QI committee will meet at least quarterly to identify QA/QI issues and to develop appropriate plans of action needed to correct the issues. The Committee monitors the effect of the implemented changes and makes any revisions necessary to the plan of action. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, Quality Assurance and Performance Improvement (QAPI) Policy and Procedure, dated 2025 revealed the facility implemented a comprehensive QAPI program which addresses all the care and unique services that the facility provides .the IP shall report to the facility's governing body on the facility's infection prevention and control program and on incidents such as healthcare associated infections on a regular basis; the IP shall attend each QAPI meeting in order to be considered an active participant and if the IP cannot attend a QAPI meeting, then another staff member of the facility may attend in lieu of the IP but that does not change or absolve the IP's responsibility to fulfill the role of a QAA committee member or reporting on the facility's infection control and prevention program.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on record review, observations, interviews, review of hospital discharge summaries, review of the Ohio Department of Health (ODH) Ohio Disease Reporting System (ODRS), review of the Summit County Public Health (SCPH) Public Health Nurse (PHN) communications, and facility policy review, the facility failed to develop, maintain, and implement an effective infection control program. This had the potential to affect all 54 residents residing in the facility. The failed to follow the local health department's directives for Resident #24 with a MDRO. This affected one resident (#24) of one resident reviewed for a MDRO and had the potential to affect all residents. The facility failed to ensure infection control tracking was not complete or accurate. This had the potential to affect all residents. The facility failed to have effective COVID-19 outbreak testing, or infection surveillance for staff and residents. The affected 20 residents (#2, #9, #11, #16, #18, #21, #22, #31, #35, #36, #37, #38, #40, #41, #42, #43, #44, #46, #47, and #55) and had the potential to affect all residents. The facility failed to have an effective legionella water management program. This had the potential to affect all residents. The facility failed to ensure EBP, transmission-based precautions (TBP) and/or contact precautions were in place for Residents #10, #14, #25, #30, #38, #49, and #204. This affected seven residents (#10, #14, #25, #30, #38, #49, and #204) of 12 residents reviewed for infection control and had the potential to affect all residents. The facility failed to ensure maintain proper infection control practices while providing wound care for Resident #11. This affected one resident (#11) of two residents reviewed for wound care. The facility failed to ensure tuberculosis screening upon hire for four employees (Administrator, Housekeeping Supervisor #306, Activities Director #330 and Receptionist #335) of ten employee personnel files reviewed. This had the potential to affect all residents. Findings include: 1. Review of the medical record for Resident #24 revealed admitted [DATE] with diagnoses including dementia with psychotic disturbance, hypertension, hyperlipidemia, lymphedema, Parkinson's disease, anxiety disorder, and atherosclerotic heart disease. Review of a nurses note dated 11/05/24 revealed Resident #24 stated he was not feeling well. Resident #24 had a temperature of 101.4 degrees Fahrenheit (F), blood pressure of 132/87, oxygen saturation of 93 percent, and heart rate of 117. Resident #24 was sent to hospital for evaluation. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Review of the hospital discharge summary dated 11/11/24 revealed Resident #24 was admitted to hospital from 11/05/24 to 11/11/24 for sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, leading to widespread inflammation and organ damage). It was noted blood and respiratory cultures had no growth.

Review of a nurses note dated 11/20/24 timed 7:30 A.M. revealed Resident #24 complained of being cold and not feeling well.

Review of a nurse's note dated 11/20/24 timed 1:58 P.M. revealed Resident #24 had a temperature of 99.8 degrees F and symptoms had not improved. Resident #24 was sent to hospital for evaluation.

Review of the hospital discharge summary dated 11/24/24 revealed Resident #24 was admitted to hospital from 11/20/24 to 11/24/24 for cellulitis (an acute bacterial infection of the skin and underlying tissues) of the left lower extremity. Resident #24 admitted for recurrent left lower extremity cellulitis and had previously been admitted from 11/05/24 to 11/11/24. Resident #24 was noted to have Methicillin-resistant Staphylococcus aureus (MRSA) growth on the sputum culture, so doxycycline (antibiotic) was added. The sputum culture appeared consistent with colonization (the presence and multiplication of microorganisms on or within a host organism without causing any apparent symptoms or disease).

Review of a Nurse Practitioner (NP) progress note dated 11/25/24 revealed Resident #24 returned from hospital on 11/24/24 with a diagnosis of cellulitis. The NP noted Resident #24 was discharged on an antibiotic for cellulitis and MRSA in the sputum culture.

Review of a NP progress note dated 12/16/24 revealed Resident #24 completed an oral antibiotic treatment of cephalexin for cellulitis and doxycycline for MRSA of sputum on 12/02/24.

Review of a nurses note dated 02/24/25 revealed Director of Nursing (DON) spoke with Resident #24's daughter regarding concerns about testing. The DON assured Resident #24's daughter the test would be completed, and she would be notified when the sample was sent to the lab. There was no specification regarding what the test was for.

Review of the current physician's orders for March 2025 revealed no evidence Resident #24 had order for enhanced barrier precautions (EBP) related to MDRO status.

Review of the plan of care for March 2025 revealed no care plan related to infections or MDRO status.

Further review of the medical record for Resident #24 revealed no additional information on Resident #24's MDRO status of colonization.

Review of the undated ODH ODRS report revealed Resident #24 had sputum culture collected on 11/10/24 while at hospital. Results of sputum culture returned on 11/27/24 and were positive for Citrobacter koseri and Klebsiella aerogenes. Klebsiella pneumoniae carbapenemase (KPC) was detected.

Review of the facility infection control logs from November 2024 to February 2025 revealed no evidence Resident #24's MDRO infection was logged, tracked, or monitored.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of documented notes from SCPH PHN #370 revealed: On 12/04/24 PHN #370 contacted the hospital requesting labs and provider notes with information on Resident #24's location of residence. On 12/10/24 PHN #370 attempted phone contact to facility without success. On 12/18/24 PHN #370 attempted phone contact to facility without success. On 12/27/24 PHN #370 attempted phone contact to facility. PHN #370 was able to obtain DON's email address and email communication was sent. On 01/07/25 PHN #370 had not received response to email to DON. A follow-up call was placed to facility and voicemail was left for Admissions/Social Service Designee (SSD) #355. SSD #355 returned phone call and confirmed Resident #24 had not been in EBP. PHN #370 provided education on colonization screening and would send follow up email with more information. DON returned call to PHN #370 and was also educated on EBP and screening needs. On 01/15/25 PHN #370 had not received follow up from facility on initiating colonization screening. PHN #370 left voicemail for SSD #355. On 01/17/25 PHN #370 was contacted by Chief Operating Officer (COO) #300. PHN #370 forwarded email with screening recommendations, swab request form, and education. On 01/27/25 PHN #370 had not received screening request forms and placed follow up call to COO #300 without successful contact. On 02/04/25 PHN #370 had not received follow up for screening from facility. SCPH Medical Director called facility and spoke with the Administrator. The Administrator indicated the facility was having turnover and requested email be forwarded to her. On 02/12/25 PHN #370 received a request for testing kits from DON. On 02/28/25 PHN #370 noted the facility was scheduled to perform screening on 02/17/25; however. No results had returned. PHN #370 followed up with lab and discovered no specimens were received from facility. Review of email communication dated 12/27/24 at 3:01 P.M. from SCPH PHN #370 addressed to Registered Nurse (RN)/Former DON #313 revealed PHN #370 notified facility of Resident #24 was reported to SCPH for a carbapenemase producing organism (CPO) and PHN #370 requested more information. It was noted Resident #24 should be on EBP. Review of email communication dated 01/07/25 at 2:56 P.M. from SCPH PHN #370 addressed to Former DON #313 and SSD #355 revealed PHN #370 provided educational materials and instructions for Carbapenemase Producing Carbapenem Resistant Enterobacteriaceae (CP-CRE) screening. PHN #370 indicated Point-Prevalence Screening (PPS) should be completed on Resident #24's unit. Resident #24 was identified as the index case and should be on EBP. Screenings were by rectal swab and must be completed on an agreed collection date. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of email communication dated 01/17/25 at 11:55 A.M. from SCPH PHN #370 addressed to COO #300 revealed PHN #370 forwarded email sent to Former DON #313 and SSD #355. Review of email communication dated 02/04/25 at 1:41 P.M. from SCPH PHN #370 addressed to the Administrator revealed PHN #370 re-sent email sent to Former DON #313, SSD #355, and COO #300. Review of email communication dated 02/10/25 at 11:23 A.M. from COO #300 addressed to SCPH PHN #370 revealed COO #300 attached order form for rectal swab test kits with no specification of number of kits needed. Review of email communication dated 02/12/25 at 10:09 A.M. from Former DON #313 addressed to SCPH PHN #370 revealed Former DON #313 attached consent forms for five swab culture kits. Review of Laboratory Report dated 03/05/25 revealed a rectal swab was obtained on 02/28/25 for Resident #24 and KPC gene deoxyribonucleic acid (DNA) was detected. Review of Laboratory Report dated 03/05/25 revealed rectal swabs were obtained on 02/28/25 for Residents #34 and #46. Residents #34 and #46 were identified to share a bathroom with Resident #24. Residents #34 and #46's swabs were negative for any detectable genes. Observation on 03/10/25 at 12:55 P.M. revealed Resident #24 was on EBP. Observation on 03/11/25 at 5:55 A.M . revealed Resident #24 was changed to contact precautions. Interview on 03/11/25 at 9:55 A.M. with PHN #370 revealed the facility had been difficult to contact and did not complete screening as scheduled. PHN #370 indicated Resident #24 was the index case and due to colonization status needed to be on EBP. PHN #370 indicated screening was necessary to determine if there had been any transmission. Interview on 03/11/25 at 11:53 A.M. with the DON confirmed she had changed Resident #24 from EBP to contact precautions as she had noticed report of CRE in sputum. DON indicated she became aware of the issue in a care conference with Resident #24's daughter. The DON indicated in her investigation she realized the facility had been contacted by SCPH, and there were required screenings to be done. She collected the samples and got the swabs sent out for testing. Interview on 03/11/25 at 1:59 P.M. with SSD #355 revealed she became involved with SCPH via phone. SSD #355 indicated the DON was on vacation and she took a message. SSD #355 indicated she relayed all information to COO #300. Interview on 03/11/25 at 2:13 P.M. with the Administrator and COO #300 confirmed SCPH had reached out about Resident #24. COO #300 indicated SCPH was working with RN/Former DON #313. Interview on 03/11/25 at 4:20 P.M. with RN/Former DON #313 revealed she was contacted sometime in January 2025 by SCPH. DON #313 indicated SCPH PHN #370 had emailed her information on EBP and screening that needed done. DON #313 indicated the screening specimens were collected mid-February 2025 and she had left the specimens for the new DON to send out. DON #313 indicated she was unaware of a 02/17/25 testing date with the lab. DON #313 indicated she was on vacation during this time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/12/25 8:23 A.M. with the DON revealed there had not been any information left for her on swabs or documentation on Resident #24's MDRO status left by Former DON #313. When she became aware, she took action to get test swabs sent to lab to comply with SCPH recommendations. The DON confirmed there was no documentation in Resident #24's medical record on MDRO status or order for EBP. Review of undated SCPH provided educational document Enhanced Barrier Precautions revealed EBP was recommended for life for diagnosed clinical cases and colonized positive residents of CPOs due to increased risk for transmission. EBP required use of gowns and gloves during high contact patient care activities including dressing, bathing, transfers, hygiene, changing linens, care of or use of medical devices, and wound care. Review of SCPH provided educational document Facility Guidance for Control of CRE dated November 2015 revealed CDC CRE tool kit was intended for all long-term care facilities. The effort to prevent transmission of resistant organisms could be coordinated by local public health. Review of the facility policy Screening and Management of Residents with Infections dated 05/01/22 revealed the infection preventionist would maintain a log of residents with current evidence of infection or colonization due to MDRO. Room placement should be considered to prevent placing a resident with MDRO with a resident at high risk for infection. A resident admitted with colonization of MDRO should be reviewed prior to return for details of the status and any possible infection control risks the situation presents. Review of the facility policy Infection Surveillance dated 10/27/21 revealed cultures may be sent for infections or colonization with epidemiologically important organisms. All MDRO reports required immediate attention to ensure appropriate precautions were in place and notifications were made. The infection control committee would communicate important surveillance data to state and local health departments. 2. Review of infection control logs from January 2024 to December 2024 revealed that starting in June 2024 logs were not completed appropriately to adequately track and trend infections. Identified infections did not include dates of onset, culture or testing results, symptoms, if resident was placed on isolation, or if organisms were sensitive to medications. The Infection Preventionist (IP) had only recorded the residents' name, room number, general infection type and antibiotic ordered. There was no evidence of ongoing analysis of infection data. Review of the Antibiotic Use Audit Tool for January 2025 and February 2025 revealed COO #300 had audited use of antibiotics for infections. There was no evidence of complete and accurate infection control tracking or trends. Interview on 03/10/25 at 12:01 P.M. with COO #300 revealed she was unsure if there was a full 12 months of infection control logs. COO #300 indicated she had started an infection control book for January 2025 and February 2025. Interview on 03/12/25 at 8:23 A.M. with the DON confirmed infection control tracking was not complete or accurate. There was not much available to review for the past 12 months. The facility should be tracking infections on a log and using mapping to identify patterns. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Review of the facility policy Infection Surveillance dated 10/27/21 revealed the infection preventionist was responsible for gathering and interpreting surveillance data. Surveillance data should include identifying information of resident, diagnoses, admitted , date of onset of infection, site of infection, pathogens, risk factors, pertinent remarks on signs and symptoms, if resident was admitted to hospital or other outcomes, and treatment measures and precautions. Monthly data should be collected and entered onto a line listing report then data should be summarized for each nursing unit by site and pathogen. Predominant pathogens or sites should be identified for trending.

3. Observation on 03/10/25 at revealed there were no current residents on isolation for COVID-19.

Interview on 03/11/25 at 11:25 A.M. with COO #300 revealed she was aware there were a few cases of COVID-19 in December 2024 but was trying to get a list from the Former DON #313.

Interview on 03/12/25 at 4:50 P.M. with COO #300 confirmed there was no COVID-19 infection tracking. COO #300 indicated the last outbreak was handled by the Former DON #313 and Former Assistant DON (ADON) #368.

Interview on 03/13/25 at 8:22 A.M. with SCPH Staff #371 revealed she was responsible for COVID-19 tracking in the community. SCPH #371 indicated there was an online form that facilities could fill out weekly for reporting purposes. SCPH #371 indicated they asked facilities to fill out the form even if there were no cases of COVID-19. SCPH #371 indicated the last data submitted for the facility was for 12/04/24. SCPH #371 indicated there had been no data submitted about a COVID-19 outbreak in December 2024. SCPH #371 indicated the facility needed to report COVID-19 cases or outbreaks to be considered compliant.

Interview on 03/13/25 at 12:25 P.M. with Resident #22 confirmed he had COVID-19 in December 2024. Resident #22 stated staff wore appropriate personal protective equipment (PPE) while in his room and they moved his roommate to another room.

Despite multiple requests on 03/10/25, 3/11/25, 03/12/25, and 03/13/25 the facility was unable to provide any COVID-19 infection tracking.

On 03/13/25 the surveyor completed a record review of residents residing in the facility. It was discovered that Residents #2, #11, #16, #18, #21, #22, #31, #37, #42, #43, #44, #47, and #55 tested positive for COVID-19 on 12/27/24. Resident #31 tested positive for COVID-19 while in the hospital. It was discovered that Resident #38 tested positive for COVID-19 on 12/30/24. It was discovered that Resident #35 tested positive for COVID-19 on 01/01/25. It was discovered that Residents #9, #40, #41, #46 tested positive for COVID-19 on 01/03/25. There was no evidence able to be obtained on staff positives for COVID-19, and no staff identified themselves as having COVID-19. Residents #9, #16, #35, #40, #41, and #46 had no identified orders for transmission-based precautions (TBP) related to COVID-19 positive status. Residents #21, #22, #37, #42, #47, and #55 TBP orders were added on 12/28/24. Residents #2, #11, #18, #34, #38, #43, and #44 TBP orders were added on 12/30/24. It was discovered that there was no evidence COVID-19 positive Resident #22's roommate COVID-19 negative Resident #36 was moved until 12/30/24.

Attempts on 03/13/25 and 03/17/25 to reach Former DON #313 and Former ADON #368 via phone were unsuccessful.

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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Interview on 03/17/25 at 8:00 A.M. with Certified Nurse Aide (CNA) #305 and CNA #353 revealed they had not been on the schedule when the COVID-19 outbreak started in December 2024. Both nurse aides recalled there being plenty of PPE and isolation in place for COVID-19 positive residents. Neither CNA #305 or CNA #353 could recall the testing procedures followed during the outbreak.

Interview on 03/17/25 at 9:06 A.M. with Central Supply/Scheduler #338 confirmed there were cases of COVID-19 in December 2024 among staff and residents. Central Supply/Scheduler #338 indicated she knew there was a whole facility round of testing done. Central Supply/Scheduler #338 indicated Former DON #313 and Former ADON #368 were completing the testing. Central Supply/Scheduler #338 indicated she was not sure who the staff were that had COVID-19, and there was no method for monitoring staff illness.

Interview on 03/17/25 at 11:27 A.M. with COO #300, Administrator, and RN/IP #374 revealed RN/IP #374 was not employed by the facility but had been assisting the facility with infection control in interim between IPs. RN/IP #374 indicated she knew there was a COVID-19 outbreak in December 2024. Surveyor identified COVID-19 cases were reviewed with COO #300, Administrator, and RN/IP #374, and COO #300 indicated she did not know there were so many cases. COO #300, Administrator, and RN/IP #374 were unable to provide additional information related to the COVID-19 outbreak, outbreak testing, or infection surveillance.

Interview on 03/17/25 at 2:26 P.M. with NP #363 revealed Resident #31 was sent to the hospital after a fall on 12/26/24. NP #363 indicated they were made aware Resident #31 tested positive for COVID-19 at the hospital and the facility did whole house testing on 12/27/24. NP #363 reported no concerns with COVID-19 management at the facility.

Review of the facility policy COVID-19 Precautions and Prevention dated 10/05/22 revealed the IP should maintain communication and collaboration with state and local health authorities including notification. IP should conduct frequent monitoring and surveillance for new respiratory illnesses. An outbreak would be declared when one case had suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or more than three residents or staff display new-onset respiratory symptoms within 72 hours of each other. IP should follow the local health department's recommendations for the next steps on managing a COVID-19 outbreak.

4. Interview on 03/11/25 at 11:25 A.M. with COO #300 revealed she was unable to find the legionella water management program binder.

Interview on 03/11/25 at 1:08 P.M. with Administrator confirmed she was unable to locate any evidence of water management program or evidence of water temperature logs.

The facility provided documents Water Management Plan for Potable Water and policies on Legionella Water Management on 03/12/25.

Interview on 03/17/25 at 11:27 A.M. with Administrator, COO #300, and RN/IP #374 confirmed they were unable to locate any additional information on legionella water management program. COO #300 confirmed provided Water Management Plan for Potable Water and policy for Legionella Water Management did not meet requirements for assessing risk, measures to prevent growth of Legionella in building water systems based on nationally accepted standards, or method for monitoring measures in place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility Water Management Plan for Potable Water revealed a section indicating water system was fed bottom-up, potable water system had two loops, there were no holding tanks for potable water, there were two water mains from public water supply with one for potable water and one for sprinkler system, and water mains were equipped with backflow preventers. The plan went on to indicate an environmental assessment would be updated annually and as needed. There was no evidence of an environmental assessment being completed. From the environmental assessment water testing would be completed. There was no evidence of water testing or sampling completed. There was no evidence of lab testing samples. Review of the facility policy Legionella dated 07/01/23 revealed the facility would establish protocols for prevention and control of transmission of Legionnaire's disease including conducting sampling of potable water per facility's water management plan, disinfecting water distribution system using a high temperature flush, and keeping a log reflecting flushes. Review of the facility policy Legionella Water Management dated 05/01/22 revealed as part of the facility's infection control program there would be a water management team to oversee water management program. The team would include an infection preventionist, administrator, medical director, director of maintenance, and director of environmental services. The water management program would be based on Centers for Disease Control and Prevention (CDC) and American Society of Heating, Refrigeration, and Air-Conditioning Engineers (ASHREA) recommendations. The water management program would include a detailed description and diagram of water system in the facility, identification of areas in water system that could encourage growth and spread, identification of situations that could lead to growth, specific measures used to control, control limits or acceptable parameters, diagram of where control measures are applied, a system to monitor control limits and effectiveness, a plan for when control limits are not met, and documentation of program. 5. Observations on 03/10/25 from 12:18 P.M. to 12:55 P.M. revealed Residents #11, #20, #24, #30, #39, and #43 were identified as on EBP. There was signage for EBP instructions and to see nurse before entering and PPE was available at the entrance to the room. It was not clear which resident in the shared room for Resident #11 and #39 was on EBP. Resident #25 was identified as on contact precautions. There was signage for contact precautions instructions and a door hanger with PPE on the back of the door that contained gloves and red biohazard bags. There were no gowns readily available for Resident #25. Interview on 03/10/25 at 12:43 P.M. with Licensed Practical Nurse (LPN) #369 revealed she worked for an agency and it was only her second time working at this facility. LPN #369 indicated she was unsure why Resident #25 was on contact precautions. Follow up tour on 03/10/25 from 4:10 P.M. to 4:18 P.M. the DON revealed that she had been working at the facility for approximately three weeks and verified that she had not yet provided the survey team with the requested list of residents on precautions. She observed Residents #11, #20, #24, #30 and #43 and confirmed the residents were on EBP. The DON observed Resident #25 and confirmed the resident was on contact precautions for a Clostridium difficile (C. diff) infection, but it was cleared now. She indicated the signage needed changed to EBP. The DON confirmed there were no gowns readily available for Resident #25, and she verified Residents #11, #20, #24, #25, #30, and #43 all required EBP or TBP. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on 03/11/25 from 5:45 A.M. to 5:55 A.M. revealed Residents #10, #14, #38, and #204 were newly placed on EBP, and Resident #24 was changed to contact precautions. Interview on 03/11/25 at 8:00 A.M. with the DON confirmed she had added Residents #10, #14, #38, and #204 to require EBP. She had not had the opportunity to verify all residents' EBP and TBP orders yet, and Former DON #313 had not ensured this task was accurate or completed. Review of list of residents on EBP, TBP, and/or contact precautions dated 03/11/25 revealed Resident #10 was on EBP for a feeding tube, Resident #204 was on EBP for a Foley catheter, Resident #38 was on EBP for a feeding tube, Resident #11 was on EBP for a wound, Resident #20 was on EBP for a feeding tube, Resident #25 was on EBP for a dialysis catheter, Resident #14 was on EBP for a feeding tube, and Resident #43 was on EBP for a wound. Resident #24 was on contact precautions for CRE in the sputum. Follow up interview on 03/11/25 at 11:53 A.M. with the DON confirmed she had changed Resident #24 to contact precautions from EBP as she had noted the resident had a MDRO in the sputum. The DON provided a list of residents on EBP and TBP which did not include Resident #30 for EBP. Review of the facility policy Transmission Based Precautions dated 05/01/22 revealed contact precautions would be implemented for residents known or suspected of being infected with microorganisms that could be transmitted by direct contact with the residents or indirect contact with environmental surfaces. A gown was required for entering a room with contact precautions. EBP would be implemented for residents during high contact care activities that provide opportunities for transfer of MDRO to staff. EBP would be used for residents with wounds, indwelling medical devices, and those with MDRO infection or colonization. EBP would be required for the duration of a resident's stay in the facility or until the resolution of medical device or wound. Review of the undated facility signage for contact precautions revealed everyone must clean hands before entering and when leaving the room. Providers and staff must apply gloves and gowns prior to entry and use dedicated or disposable equipment. Review of the undated facility signage for EBP revealed everyone must clean hands before entering and when leaving the room. Providers and staff must apply gloves and gowns for high contact activities including dressing, bathing, transfers, changing of linens, providing hygiene care, providing toileting or incontinence care, medical device care, and wound care. 43063 6. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including heart failure, chronic respiratory failure, kidney failure, obesity and cirrhosis of the liver. Review of the physician's orders for Resident #49 revealed a treatment order for Triad Hydrophilic Wound Dress External Paste (debriding paste utilized as a wound dressing), apply to buttock topically two times a day dated 02/26/25. There were no orders for Resident #49 to be on EBP (gown and gloves) during care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 03/12/25 at 2:33 P.M. of wound care to Resident #49 with NP #364 (wound nurse) and the DON revealed he had a Stage III pressure ulcer to Resident #49's right buttock. NP #364 and DON washed their hands prior to wound care and donned gloves. There were no gowns available in the room, and there was no sign on the door revealing Resident #49 was on EBP. Interview on 03/12/25 at 3:40 P.M. with the DON verified Resident #49 did not have an order for EBP, but he should have had one due to the Stage III pressure ulcer to his right medial buttock. Review of the facility policy titled, Transmission Based Precautions dated 05/01/22 revealed EBP should be implemented for high contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and or clothing. The use of gown and gloves for high contract resident care activities was indicated when contact precautions would not apply otherwise for nursing homes residents with wound and/or indwelling medical devices regardless of MDRO colonization as well as residents with MDRO infection or colonization. Examples of high contact resident care activities requiring gown and gloves are providing hygiene, device care such as urinary catheter and wound care. 7. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including dementia with behavioral disturbance and non-compliance. Review of the physician's orders for March 2025 revealed an order initiated on 11/26/24 for hospice was to change Resident #11's wound dressings on Tuesdays and Thursdays on night shift. On 02/26/25 an order was initiated for staff to apply Skin Prep (forms a film to protect the skin by reducing friction) daily to the right side of the foot and then leave the foot in the boot at bedtime for wound care. Observation on 03/12/25 at 2:33 P.M. of wound care with the DON and NP #364 (wound nurse) to Resident #11's right lateral foot. During the dressing change and assessment, NP #364 removed Resident #11's dressing, removed the scab to the wound, measured the wound and then applied Skin Prep via wipe. NP #364 then placed a dry dressing over the wound. NP #364 was asked if the Skin Prep was a cleansing agent, and she verified it was not a cleansing agent but was like a liquid band-aid. NP #364 stated the wound had been cleaned during the last dressing change earlier in the night or day shift. Interview on 03/12/24 at 3:40 P.M. with the DON verified NP #364 did not cleanse Resident #11's right lateral foot wound during the dressing change. Review of the facility policy titled, Wound Care dated 05/01/22 revealed the facility would ensure all residents skin conditions were properly tracked and cared for. 8. Review of the medical record for Resident #204 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, hypertension, diabetes mellitus, Alzheimer's disease and dementia. Review of Resident #204's nursing admission assessment dated [DATE] revealed he had an indwelling Foley catheter in place. There was no documentation related to Resident #204 needing to be placed on EBP. Observation on 03/12/25 at 10:40 A.M. of care to Resident #204 by CNA #305 and CNA #353 revealed he had an indwelling Foley catheter. CNA #305 and CNA #353 washed their hands, donned gloves and then provided Foley catheter care to Resident #204. There were no gowns available in the roo [TRUNCATED]

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Momentous Health at Richfield	4360 Brecksville Rd Richfield, OH 44286

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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 0881

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Implement a program that monitors antibiotic use.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44457

Based on interview, record review, review of infection control logs, and review of facility policy, the facility failed to ensure implementation of appropriate antibiotic stewardship measures. This affected one Resident (#9) of three reviewed for urinary tract infections and 15 residents (#2, #9, #19, #23, #24, #25, #29, #32, #33, #35, #37, #42, #43, #50, and #55) of 15 residents reviewed in the infection control log. The facility census was 54.

Findings include:

1. Review of the medical record for Resident #9 revealed an admitted [DATE] and diagnoses including bell's palsy, systemic lupus erythematosus, congestive heart failure, hypertension, dementia, metabolic encephalopathy, malignant neoplasm of bronchus and lung, and chronic kidney disease.

Review of the nurses note dated 01/11/25 revealed Resident #9 was agitated and adamant she was going home. Resident #9's son came to the facility to try to calm her down and he reported that Resident #9 was exhibiting symptoms of a urinary tract infection (UTI) as she had in the past. Hospice and the residents physician were notified. The physician gave an order for Ciprofloxacin (Cipro) for seven days and to collect a urine sample.

Review of Resident #9's physician's orders for January 2025 revealed no documented evidence of an order for a urine sample.

Review of Resident #9's laboratory results for January 2025 revealed no documented evidence of a urinalysis or culture completed to support the antibiotic treatment for UTI symptoms.

Review of the Antibiotic Use Audit Tools for January 2025 revealed on 01/11/25 Resident #9 received Cipro with an indication for use of a UTI. The tool indicated Resident #9 did not meet McGeer's Criteria, indicating that the resident did not exhibit the necessary signs, symptoms, and/or laboratory findings to be definitively diagnosed with a UTI.

Review of Resident #9's physician's order dated 01/12/25 revealed an order for Ciprofloxacin 500 milligrams (mg) two times per day for seven days.

Review of Resident #9's physician's order dated 01/21/25 revealed order for Macrobid (Nitrofurantoin) 100 mg two times per day for an unspecified number of days. The order was discontinued on 02/04/25.

Review of the Antibiotic Use Audit Tools for January 2025 revealed on 01/21/25, Resident #9 received Nitrofurantoin with an indication for use of a UTI. The tool indicated Resident #9 did not meet McGeer's Criteria, indicating that the resident did not exhibit the necessary signs, symptoms, and/or laboratory findings to be definitively diagnosed with a UTI.

Interview on 03/17/25 at 10:32 A.M. with Chief Operating Officer (COO) #300 confirmed she was unable to find a urinalysis completed for Resident #9 in January 2025 when Resident #9 was treated with an antibiotic for UTI symptoms.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Richfield	4360 Brecksville Rd Richfield, OH 44286

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/17/25 at 2:26 P.M. with Nurse Practitioner (NP) #363 indicated Resident #9's family reported she had history of UTI's and she was on hospice. NP #363 indicated she did not find it unusual for hospice to treat symptoms. 2. Review of the infection control logs from January 2024 to December 2024 revealed starting in June 2024, logs were not completed appropriately to adequately track and trend infections. Identified infections did not include the date of onset, culture or testing results, symptoms, if the resident was placed on isolation, or if organisms were sensitive to medications. The log had only recorded the residents' name, room number, general infection type and antibiotic ordered. Fifteen residents (#2, #9, #19, #23, #24, #25, #29, #32, #33, #35, #37, #42, #43, #50, and #55) were identified in the incomplete infection control log from June 2024 to December 2024. Review of the Antibiotic Use Audit Tool for January 2025 and February 2025 revealed Chief Operating Officer (COO) #300 had audited the use of antibiotics for infections. COO #300 had indicated none of the residents with infections that were treated with antibiotics had met McGeer's Criteria, indicating that the resident did not exhibit the necessary signs, symptoms, and/or laboratory findings to be definitively diagnosed with an infection. Interview on 03/10/25 at 12:01 P.M. with COO #300 revealed she was unsure if there was a full 12 months of infection control logs. COO #300 indicated she had started an infection control book for January 2025 and February 2025. Interview on 03/12/25 at 8:23 A.M. with Director of Nursing (DON) confirmed she was unable to locate any information on the facility's antibiotic stewardship program. DON indicated there was limited information available left for her regarding infection control in general. The DON indicated she would expect to see the use of McGeer's criteria and would have the nurse practitioner evaluate if the resident did not meet criteria for treatment with antibiotic. Interview on 03/13/25 at 11:29 A.M. with COO #300 revealed she had created logs for January and February 2025 by reviewing progress notes. COO #300 indicated a lot of the residents on the log came in from the hospital already on antibiotics. COO #300 indicated residents did not always meet McGeer's criteria, but the physician did not want to change or discontinue the antibiotic. COO #300 indicated they just followed what the physician said. Interview on 03/13/25 at 12:01 P.M. with COO #300 confirmed she did not have McGeer's criteria filled out on each infection with an antibiotic ordered, however she had cross referenced it when she created her logs. Review of facility policy Antibiotic Stewardship Program dated 07/01/23 revealed lab results would be reported to prescriber to determine if antibiotic therapy should be started, continued, modified, or discontinued. The infection preventionist would continue infection line listing and review antibiotic utilization on a monthly basis to ensure appropriate prescribing and use of antibiotics.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44457 Based on review of Quality Assurance and Performance Improvement (QAPI) meetings, staff interview, review of staff certificates and personnel files, the facility failed to ensure there was a qualified infection preventionist (IP) working on at least a part time basis. This had the potential to affect all residents residing in the facility. The facility census was 54. Findings include: Review of the Quality Assurance and Performance Improvement (QAPI) meeting sign-in sheets from March 2024 to February 2025 revealed no designation of an IP or evidence of an IP participation in meetings, except for in January 2025 and February 2025 when Chief Operating Officer (COO) #300 was present. Interview on 03/10/25 at 12:01 P.M. with COO #300 revealed there was not currently an infection preventionist (IP) employed at the facility. COO #300 indicated she held an IP certificate and Registered Nurse (RN) #374 was a Director of Nursing and IP for another facility, who was assisting with the changeover in staff. COO #300 indicated former Assistant Director of Nursing (ADON) #368 was the IP from May 2024 through December 2024. Interview on 03/11/25 at 8:00 A.M. with the Director of Nursing (DON) revealed she had an IP certificate, but was unable to provide evidence of the certificate. Interview on 03/19/25 at 2:28 P.M. with COO #300 confirmed she was unable to locate an IP certificate for the former ADON #368 and confirmed there had not been consistent participation from an IP on QAPI meetings as required. She stated she was only at the facility from January 2025 to current and was only present one day per week and RN #374 worked mostly offsite. Review of the certificate dated 06/05/20 revealed RN #374 completed IP training course with Centers for Disease Control and Prevention (CDC) via web-based training. Review of certificate dated 01/09/25 revealed COO #300 completed IP training course with CDC via web-based training. Review of the personnel file of former ADON #368 revealed no evidence of an IP certificate.

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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 0883

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Develop and implement policies and procedures for flu and pneumonia vaccinations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44457

Based on record review, review of a facility immunization report, facility policy review, review of facility census, review of Centers for Disease Control and Prevention (CDC) guidance and interview, the facility failed to ensure residents were offered, screened, educated and received influenza and pneumococcal vaccinations as required. This affected nine residents (#23, #24, #25, #26, #31, #38, #43, #55 and #204) reviewed/interviewed as part of the survey and the lack of an effective system to manage vaccinations and prevent incidents of influenza/pneumonia had the potential to affect all 54 residents residing in the facility. The facility census was 54.

Findings include:

1.Review of the facility census on 12/04/24 revealed there were 45 residents, Resident #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #18, #19, #20, #21, #22, #23, #24, #25, #27, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #40, #41, #42, #44, #45, #46, #50, #51, #55, #56, #57, and #58 who resided in the facility on this date.

Review of the facility Immunization Report from 01/01/24 to 03/13/25 revealed there was no documented evidence of any pneumococcal vaccinations completed for any residents during this time period of 01/01/24 to 03/31/25. In addition, record review revealed there was no documented evidence of consent/declination, screenings, or education regarding pneumococcal vaccinations for any facility residents during this time period.

Interview on 03/13/25 at 7:30 A.M. with the Director of Nursing (DON) revealed she was unable to find any evidence of pneumococcal vaccinations being completed as required for any residents between 01/01/24 and 03/13/25.

Review of a facility Immunizations Report from 01/01/24 to 03/13/25 revealed 23 residents (#4, #5, #7, #8, #11, #12, #15, #18, #20, #21, #24, #25, #27, #29, #32, #33, #36, #40, #41, #44, #45, #46, #51) were included on the report as having received an influenza vaccination on 12/04/24 and 12 residents (#2, #9, #10, #16, #19, #22, #23, #30, #35, #37, #38, #42) who refused the influenza vaccination. However, there was no documented evidence of consent/declination, screenings, or education regarding influenza vaccinations for any facility residents during this time period.

Interview on 03/13/25 at 12:10 P.M. with the DON confirmed she was unable to locate evidence of education or any of the 23 consents for influenza vaccinations that were completed on 12/04/24.

A follow-up interview on 03/17/25 at 11:27 A.M. with the Administrator, Chief Operating Officer (COO) #300, and Registered Nurse/Infection Preventionist (RN/IP) #374 revealed RN/IP #374 was not employed by the facility but had been assisting the facility with infection control in interim between IPs. They were unaware of how the previous DON, DON #313 and Assistant DON (ADON) #368 had been handling vaccinations and acknowledged there was a lot of missing vaccination forms. COO #300 indicated she was unsure why the annual influenza vaccinations were not administered until 12/04/24. COO #300 indicated that was the responsibility of Former DON #313 and she likely did not place her order for vaccinations in a timely manner.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A follow-up interview on 03/19/25 at 2:28 P.M. with COO #300 confirmed she was unable to locate any additional information on pneumococcal or influenza vaccinations for any residents. A follow-up interview on 03/19/25 at 3:37 P.M. with the DON confirmed she was unable to provide any additional information on pneumococcal or influenza vaccinations for any residents. Interview on 03/27/25 at 11:09 A.M. with Resident #26 revealed she was admitted right before Christmas, on 12/20/24. She stated she was never educated about or asked if she wanted the influenza or pneumococcal vaccines. She stated she would have taken the influenza vaccine. Interview on 03/27/25 at 11:13 A.M. with Resident #43 revealed he arrived in December 2024 (12/16/24) and he was never offered or educated on the influenza or pneumococcal vaccines. He stated he did not receive any vaccines while he was at the facility and he would have liked to have had them. Review of the facility policy Pneumococcal (Pneumonia) Vaccine dated 10/27/21 revealed administration of pneumococcal vaccines or revaccinations would be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at time of vaccination. Residents would be assessed for eligibility as indicated and offered within 30 days of admission to facility unless medically contraindicated or already up to date on vaccination status. The resident or legal representative would receive information and education on benefits and potential side effects. Administration and refusal would be documented in the resident's medical record. Review of the facility policy Influenza Vaccine dated 07/01/23 revealed all residents should receive influenza vaccinations annually unless there was a documented contraindication. Influenza vaccinations should be offered from October 1st through March 31st of each year. Consent and declination shall be documented in resident's medical record. 2. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including asthma and pulmonary embolism. The medical record revealed Resident #23 was her own responsible party and the resident was [AGE] years old. Review of the immunizations record revealed no historical records of the resident receiving a pneumococcal vaccination. There was no evidence of the facility offering, screening, or educating Resident #23 for pneumococcal vaccinations. The record indicated Resident #23 refused the influenza vaccination at an unspecified time; however, there was no evidence of a consent/declination, education, or rationale for it being declined. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #23 did not receive the influenza vaccine as the resident was not in the facility. The assessment also noted Resident #23 was not up to date on the pneumococcal vaccination as the resident was not assessed. On 03/13/25 at 7:30 A.M. interview with the Director of Nursing (DON) revealed she was unable to find any evidence of pneumococcal vaccination being completed as required for Resident #23. On 03/13/25 at 12:10 P.M. a follow-up interview with the DON confirmed she was unable to locate any consents or declination for the influenza vaccination for Resident #23. (continued on next page)

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F 0883

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

On 03/27/25 at 10:05 A.M. an interview with Resident #23 revealed the last vaccine she received was prior to coming to the facility. The resident denied being offered any vaccines or education while she was in the facility. During the interview, the resident indicated it was likely she would not want to receive an influenza or pneumococcal vaccination based on the preservatives in them because of her low white blood cell count.

3. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including dementia, hypertension, lymphedema, psychosis, Parkinson's disease, and atherosclerotic heart disease. The medical record revealed Resident #24 had a guardian and the residents was [AGE] years old.

Review of the immunizations record revealed no historical records of the resident receiving a pneumococcal vaccination. There was no evidence of the facility offering, screening, or educating Resident #24's guardian about pneumococcal vaccinations. The record indicated Resident #24 received the influenza vaccination on 12/04/24; however, there was no evidence of a consent, screening, or education for the vaccination.

Review of the Medicare Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #24 did not receive the influenza vaccine as the resident was not in the facility. The assessment also noted Resident #24 was not up to date on pneumococcal vaccinations as the resident was not assessed.

Interview on 03/13/25 at 7:30 A.M. with the Director of Nursing (DON) revealed she was unable to find any evidence of pneumococcal vaccination being completed as required for Resident #24.

Interview on 03/13/25 at 12:10 P.M. with the DON confirmed she was unable to locate any consents or declinations for the influenza vaccination for Resident #24.

Interview on 03/27/25 at 9:38 A.M. with Resident #24's guardian revealed she had been the resident's guardian since admission on 06/04/24 and the facility had never educated or offered immunizations, including influenza and pneumonia.

A follow-up interview on 03/27/25 at 11:44 A.M. with Resident #24's guardian the guardian revealed the resident would have taken the vaccines as she usually did get an influenza vaccine every year. It was unclear during the interview if the guardian was aware that the facility immunization log identified Resident #24 as a resident who had received the influenza vaccine.

4. Review of the medical record for Resident #25 revealed and admitted [DATE] with diagnoses including focal traumatic brain injury, vascular dementia, diabetes mellitus, end stage renal disease, dependence on renal dialysis, and bradycardia. The medical record revealed Resident #25 had an appointed guardian and the resident was [AGE] years old.

Review of the immunizations record revealed no historical records of the resident receiving a pneumococcal vaccination. There was no evidence of the facility offering, screening, or educating Resident #25's guardian about pneumococcal vaccinations. The record indicated Resident #25 received the influenza vaccination on 12/04/24; however, there was no evidence of a consent, screening, or education for the vaccination.

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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 03/31/2025
NAME OF PROVIDER OR SUPPLIER Momentous Health at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 Brecksville Rd Richfield, OH 44286	

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Medicare Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #25 received the influenza vaccination on 12/04/24. The assessment also noted that Resident #25 was not up to date on pneumococcal vaccinations as the resident was not assessed. Interview on 03/13/25 at 7:30 A.M. with the Director of Nursing (DON) revealed she was unable to find any evidence of pneumococcal vaccinations being completed as required for Resident #25. Interview on 03/13/25 at 12:10 P.M. with the DON confirmed she was unable to locate any consents or declinations for the influenza vaccination for Resident #25. Interview on 03/27/25 at 10:16 A.M. with the Administrator revealed Resident #25 was younger than [AGE] years old and she did not think the resident fit the criteria for pneumococcal vaccination. Interview on 03/27/25 at 10:20 A.M. with MDS Nurse #365 revealed it had been a year or two since he reviewed the guidance on the MDS section O for vaccines. However, he was educated through American Association of Nurse Assessment Coordinators (AANAC) that on the question for pneumococcal vaccines, you would answer yes if the resident had it, and he would look in the medical record to see if they refused it, then he would mark that, and if they were under 65 he would mark that the resident was not eligible. He stated that criteria (ineligibility) would apply to Resident #25. 5. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including traumatic subdural hemorrhage, chronic obstructive pulmonary disease (COPD), hypertension, alcohol dependence, and COVID-19 on 12/28/24. The medical record revealed Resident #38 had an appointed guardian and the resident was [AGE] years old. Review of the immunizations record revealed no historical records of the resident receiving a pneumococcal vaccination received. There was no evidence of the facility offering, screening, or educating Resident #38's guardian about pneumococcal vaccinations. The record indicated Resident #38 refused the influenza vaccination at an unspecified time; however, there was no evidence of a consent/declination, education, or rationale for it being declined. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #38 did not receive the influenza vaccine as the resident was offered and declined it. The assessment also noted that Resident #38 was not up to date on pneumococcal vaccinations as the resident was not eligible. Interview on 03/13/25 at 7:30 A.M. with the Director of Nursing (DON) revealed she was unable to find any evidence of pneumococcal vaccinations being completed for Resident #38. Interview on 03/13/25 at 12:10 P.M. with the DON confirmed she was unable to locate any consents or declinations for the influenza vaccination for Resident #38. Interview on 03/27/25 at 9:19 A.M. with the Administrator and DON revealed that, per the MDS nurse, Resident #35 was younger than [AGE] years old and did not fit the criteria for pneumococcal vaccines during the MDS assessment, based on advice from education at American Association of Nurse Assessment Coordinators (AANAC). (continued on next page)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/27/25 at 10:20 A.M. with MDS Nurse #365 revealed it had been a year or two since he reviewed the guidance on the MDS section O for vaccines. However, he was educated through American Association of Nurse Assessment Coordinators (AANAC) that on the question for pneumococcal vaccines, you would answer yes if the resident had it, and he would look in the medical record to see if they refused it, then he would mark that, and if they were under 65 he would mark that the resident was not eligible. He stated that criteria (ineligibility) would apply to Resident #38. 6. Review of the medical record for Resident #204 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, hypertension, Alzheimer's disease, and hypothyroidism. The medical record revealed Resident #204 was their own responsible party and the resident was [AGE] years old. Review of the immunizations record revealed no historical records of influenza or pneumococcal vaccinations being received by the resident. There was no evidence of the facility offering, screening, or educating Resident #204 for the influenza or pneumococcal vaccinations. Review of the Medicare Minimum Data Set (MDS) admission assessment revealed it had not yet been completed for Resident #204. Interview on 03/13/25 at 7:30 A.M. with the Director of Nursing (DON) confirmed she had not been able to locate any historical vaccination information for Resident #204 and confirmed Resident #204 had not been offered any vaccinations since admission. Interview on 03/27/25 at 9:19 A.M. with the Administrator and DON confirmed they should offer the vaccines upon admission. Interview on 03/27/25 at 11:05 A.M. with Resident #204's family revealed the facility never offered the vaccines (influenza or pneumococcal) for the resident or provided education related to them. 7. Review of the closed medical record for Resident #55 revealed an admitted [DATE] and discharge date of [DATE]. Resident #55 had diagnoses including chronic obstructive pulmonary disease, peripheral vascular disease, chronic kidney disease, dementia, and nontraumatic intracerebral hemorrhage. The medical record revealed Resident #55 had an appointed guardian and was [AGE] years old. Review of the immunizations record revealed Resident #55 was not up to date with pneumococcal vaccinations as pneumococcal Polysaccharide Vaccine (PPSV) 23 was administered before the age of 65. Review of the Nurse Practitioner (NP) progress note dated 01/09/25 revealed Resident #55 had complaints of nausea and loose stools. Stools were noted to be loose and dark tarry colored. Resident #55 reported not feeling well and not eating due to nausea and abdominal pain. Resident #55 told the nurse he was having difficulty breathing and he felt like he was dying. Resident #55 had a harsh, moist cough. The NP ordered to send Resident #55 to the emergency room for evaluation. Review of the nurse's note dated 01/09/25 revealed Resident #55 was transported to hospital for complaints of stomach pain for a few days and black stool. Resident #55 was noted to be on a blood thinner. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the nurse's note dated 01/10/25 revealed Resident #55 was admitted to hospital for pneumonia. Further review of the medical record for Resident #55 revealed no additional hospital documentation was available for review. Interview on 03/17/25 at 8:03 A.M. with the guardian of Resident #55 revealed Resident #55 had passed away at the hospital. The resident's death certificate was not available as of this date. Interview on 03/17/25 at 11:27 A.M. with Administrator, Chief Operating Officer (COO) #300, and Registered Nurse/Infection Preventionist (RN/IP) #374 revealed they were unaware Resident #55 had been hospitalized for pneumonia and subsequently passed away at hospital despite having symptoms of a change in condition since testing positive for COVID-19 on 12/27/24. They further confirmed no consents or refusals for vaccines were able to be located for Resident #55. 8. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including diabetes mellitus, bipolar disorder, hypothyroidism, muscle weakness, and unspecified intellectual disabilities. Resident #31 was hospitalized from 12/26/24 to 01/08/25. The medical record revealed Resident #31 was his own responsible party and he was [AGE] years old. Review of immunizations record revealed no evidence of Resident #31's pneumococcal vaccinations status. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #31 had severely impaired cognition and was independent for activities of daily living. The assessment revealed Resident #31 had not received pneumococcal vaccinations. Review of a Nurse Practitioner (NP) progress note dated 12/26/24 revealed Resident #31 continued to have cough and congestion. On 12/23/24 Resident #31 had a chest x-ray with no findings. On 12/24/24 Resident #31 had four to five watery stools and was ordered Loperamide two milligrams (mg) every six hours as needed for diarrhea. Resident #31 also complained of nausea and emesis. Laboratory services were ordered on 12/24/24 and were not obtained. Resident #31's pulse ox was 92 percent on room air and the resident's heart rate was 109 (tachycardic). While the NP was visiting, she was alerted Resident #31 had fallen in his room. Resident #31 was trying to walk to bathroom and became dizzy causing a fall. The NP ordered Resident #31 to be sent to the emergency room for evaluation. Review of nurse's note dated 12/27/24 revealed Resident #31 had been admitted to the hospital with acute hypoxic respiratory failure, pneumonia, dehydration, acute kidney injury, and was positive for COVID-19. Review of a hospital note revealed Resident #31 was admitted to the step-down unit on 12/26/24 for acute hypoxic respiratory failure and acute kidney injury. Resident #31 was found to have COVID-19 and pneumonia. Resident #31 had episodes of oxygen desaturation and required oxygen. Resident #31 was treated with Remdesivir, steroids and antibiotics. Remdesivir had to be stopped due to Transaminitis. Resident #31 continued to have intermittent coughing while hospitalized . Review of a NP progress note dated 01/09/25 revealed Resident #31 had readmitted to the facility from the hospital on 01/08/25. Resident #31 was diagnosed with COVID-19, pneumonia, bilateral pulmonary embolism, left leg deep vein thrombosis, and acute kidney injury. (continued on next page)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/17/25 at 11:27 A.M. with Administrator, Chief Operating Officer (COO) #300, and Registered Nurse/Infection Preventionist (RN/IP) #374 revealed they were unaware Resident #31 had been hospitalized for treatment of COVID-19 and pneumonia after the resident had been symptomatic since 12/06/24. They further confirmed no consents or refusals for vaccines were able to be located for Resident #31. Interview on 03/27/25 at 9:52 A.M. with Resident #31 revealed he was educated regarding the influenza and pneumococcal vaccines by the facility and he did consent to and received the vaccines, but he could not remember when he had them or when the education was. Resident #31 stated he knew he had to go to the hospital because he was sick, but he could not remember when it was, and he also could not remember any treatments or medications he was given prior to the hospitalization . He stated he had poor memory. Review of online Centers for Disease Control and Prevention (CDC) information/guidance for pneumococcal vaccination, dated 10/26/24 revealed the following CDC recommends pneumococcal vaccination for children younger than 5 years and adults [AGE] years or older. CDC also recommends pneumococcal vaccination for children and adults at increased risk for pneumococcal disease. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need. The CDC guidance provides additional information for the types of risk associated with pneumococcal disease for vaccination of those individuals between the ages of 5 and 49 and also provides guidance on the type of pneumococcal vaccination/schedule for administration based on an assessment of the resident.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457 Based on medical record review, review of a facility immunization report, review of staff vaccination reports, facility policy review, review of Centers for Disease Control and Prevention (CDC) guidance and interview, the facility failed ensure residents and staff were educated, screened, and offered COVID-19 vaccinations as required. This affected seven residents (#23, #24, #25, #31, #38, #55 and #204) of seven reviewed for immunizations and the lack of an effective program to manage vaccinations affected all residents in the facility. The facility census was 54. Findings include: 1. Review of the Immunizations Report from 01/01/24 to 03/13/25 for COVID-19 vaccinations revealed there was no evidence of any COVID-19 vaccinations being completed from 01/01/24 to 03/13/25. In addition, record review revealed there was no documented evidence of consent/declination, screenings, or education regarding COVID-19 vaccinations for any facility residents during this time period. Interview on 03/13/25 at 7:30 A.M. with Director of Nursing (DON) revealed she was unable to find any evidence of COVID-19 vaccinations being completed as required for any residents between 01/01/24 and 03/13/25. Follow up interview on 03/17/25 at 11:27 A.M. with Administrator, Chief Operating Officer (COO) #300, and Registered Nurse/Infection Preventionist (RN/IP) #374 revealed RN/IP #374 was not employed by the facility, but had been assisting the facility with infection control in interim between IPs. They were unaware of how the previous DON #313 and assistant DON (ADON) #368 had been handling vaccinations and acknowledged there were a lot of missing vaccination forms. Follow up interview on 03/19/25 at 2:28 P.M. with COO #300 confirmed she was unable to locate any additional information on COVID-19 vaccinations for any residents. Follow up interview on 03/19/25 at 3:37 P.M. with the DON confirmed she was unable to provide any additional information on COVID-19 vaccinations for any residents. Review of facility policy Resident COVID-19 Vaccine dated 05/01/22 revealed all residents and employees who had no medical contraindications will be offered the COVID-19 vaccine. The facility shall provide education on risks and benefits of vaccine. Administration or declination shall be documented in the resident medical record and employee personnel record. Vaccines shall be administered in accordance with current Centers for Disease Control and Prevention (CDC) recommendations. Review of the CDC guidance titled Staying Up to Date with COVID-19 Vaccines dated 01/07/25 revealed everyone over six months of age should receive the 2024 to 2025 COVID-19 vaccination to best protect from currently circulating strains. Review of the CDC guidance on COVID-19 dated 03/10/25 revealed the COVID-19 vaccination was recommended for prevention of severe health outcomes. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the medical record for Resident #23 revealed an admitted [DATE] and diagnoses including asthma and pulmonary embolism. The medical record revealed Resident #23 was her own responsible party. Review of the immunizations record revealed no historical records of the resident receiving COVID-19 vaccinations. There was no evidence of the facility offering, screening, or educating Resident #23 for COVID-19 vaccinations. Review of the Medicare Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #23 was not up to date on COVID-19 vaccinations. Interview on 03/13/25 at 12:10 P.M. with the Director of Nursing (DON) confirmed she was unable to locate any consents or declinations for COVID-19 vaccinations for Resident #23. On 03/27/25 at 10:05 A.M. an interview with Resident #23 revealed the last vaccine she received was prior to coming to the facility. The resident denied being offered any vaccines or education while she was in the facility. 3. Review of the medical record for Resident #24 revealed an admitted [DATE] and diagnoses including dementia, hypertension, lymphedema, psychosis, Parkinson's disease, and atherosclerotic heart disease. The medical record revealed Resident #24 had a guardian. Review of the immunizations record revealed Resident #24 had received doses of COVID-19 vaccinations prior to admission on 07/15/21, 08/12/21, and 11/02/22. There was no evidence of the facility offering, screening, or educating Resident #24's guardian about COVID-19 vaccinations. Review of the Medicare Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #24 was not up to date on COVID-19 vaccinations. Interview on 03/13/25 at 12:10 P.M. with the Director of Nursing (DON) confirmed she was unable to locate any consents or declinations for COVID-19 vaccinations for Resident #24. Interview on 03/27/25 at 9:38 A.M. with Resident #24's guardian revealed she had been the resident's guardian since admission on 06/04/24 and the facility had never educated or offered immunizations. 4. Review of the medical record for Resident #25 revealed and admitted [DATE] and diagnoses including focal traumatic brain injury, vascular dementia, diabetes mellitus, end stage renal disease, dependence on renal dialysis, and bradycardia. The medical record revealed Resident #25 had an appointed guardian. Review of the immunizations record revealed no historical records of the resident receiving COVID-19 vaccinations. There was no evidence of the facility offering, screening, or educating Resident #25's guardian about COVID-19 vaccinations. Review of the Medicare Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #25 was not up to date on COVID-19 vaccinations. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/13/25 at 12:10 P.M. with the Director of Nursing (DON) confirmed she was unable to locate any consents or declinations for COVID-19 vaccinations for Resident #25. 5. Review of the medical record for Resident #38 revealed an admitted [DATE] and diagnoses including traumatic subdural hemorrhage, chronic obstructive pulmonary disease (COPD), hypertension, and COVID-19 on 12/28/24. The medical record revealed Resident #38 had an appointed guardian. Review of the immunizations record revealed no historical records of the resident receiving COVID-19 vaccinations. There was no evidence of facility offering, screening, or educating Resident #38's guardian about COVID-19 vaccinations. Review of the Medicare Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed Resident #38 was not up to date on COVID-19 vaccination. Interview on 03/13/25 at 12:10 P.M. with DON confirmed she was unable to locate any consents or declinations for COVID-19 vaccinations for Resident #38. 6. Review of the medical record for Resident #204 revealed an admitted [DATE] and diagnoses including paranoid schizophrenia, hypertension, Alzheimer's disease, and hypothyroidism. The medical record revealed Resident #204 was their own responsible party. Review of the immunizations record revealed no historical records of COVID-19 vaccinations being received by the resident. There was no evidence of the facility offering, screening, or educating Resident #204 for COVID-19 vaccinations. Review revealed the Medicare Minimum Data Set (MDS) admission assessment had not yet been completed for Resident #204. Interview on 03/13/25 at 7:30 A.M. with Director of Nursing (DON) confirmed she had not been able to locate any historical vaccination information for Resident #204 and confirmed Resident #204 had not been offered any vaccinations since admission. Interview on 03/27/25 at 11:05 A.M. with Resident #204's family revealed the facility never offered vaccines to the resident or provided education related to them. 7. Review of the closed medical record for Resident #55 revealed an admitted [DATE] and discharge date of [DATE]. Resident #55 had diagnoses including chronic obstructive pulmonary disease, peripheral vascular disease, chronic kidney disease, dementia, and nontraumatic intracerebral hemorrhage. The medical record revealed Resident #55 had an appointed guardian and was [AGE] years old. Review of the immunizations record revealed Resident #55 was not up to date with the COVID-19 vaccinations, with the last dose administered 06/02/22. Review of the nurse's note dated 12/27/24 revealed Resident #55 tested positive for COVID-19. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Nurse Practitioner (NP) progress note dated 12/30/24 revealed Resident #55 had nasal congestion. The NP ordered oxygen via nasal cannula to keep oxygen saturation above 92 percent, Dexamethasone six mg daily for seven days, and monitor temperature, pulse oximetry (ox), and respirations every shift for 10 days. The NP noted to continue Eliquis five mg twice per day, Acetaminophen 650 mg every six hours as needed, and Albuterol nebulizer every four hours as needed. Review of the Nurse Practitioner (NP) progress note dated 01/09/25 revealed Resident #55 had complaints of nausea and loose stools. Stools were noted to be loose and dark tarry colored. Resident #55 reported not feeling well and not eating due to nausea and abdominal pain. Resident #55 told the nurse he was having difficulty breathing and he felt like he was dying. Resident #55 had a harsh, moist cough. The NP ordered to send Resident #55 to the emergency room for evaluation. Review of the nurse's note dated 01/09/25 revealed Resident #55 was transported to hospital for complaints of stomach pain for a few days and black stool. Resident #55 was noted to be on a blood thinner. Review of the nurse's note dated 01/10/25 revealed Resident #55 was admitted to hospital for pneumonia. Further review of the medical record for Resident #55 revealed no additional hospital documentation was available for review. Review of the Ohio Department of Medicaid Facility Communication dated 01/16/25 revealed Resident #55 had passed away at the hospital on 01/10/25. Interview on 03/17/25 at 8:03 A.M. with the guardian of Resident #55 revealed Resident #55 had passed away at the hospital. The resident's death certificate was not available as of this date. Interview on 03/17/25 at 11:27 A.M. with Administrator, Chief Operating Officer (COO) #300, and Registered Nurse/Infection Preventionist (RN/IP) #374 revealed they were unaware Resident #55 had been hospitalized for pneumonia and subsequently passed away at hospital despite having symptoms of a change in condition since testing positive for COVID-19 on 12/27/24. They further confirmed no consents or refusals for vaccines were able to be located for Resident #55. 8. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including diabetes mellitus, bipolar disorder, hypothyroidism, muscle weakness, and unspecified intellectual disabilities. Resident #31 was hospitalized from 12/26/24 to 01/08/25. The medical record revealed Resident #31 was his own responsible party. Review of the immunizations record revealed no evidence of Resident #31's COVID-19 vaccinations status. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #31 had severely impaired cognition and was independent for activities of daily living. The assessment revealed Resident #31 was not up to date on COVID-19 vaccinations. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a Nurse Practitioner (NP) progress note dated 12/26/24 revealed Resident #31 continued to have cough and congestion. On 12/23/24 Resident #31 had a chest x-ray with no findings. On 12/24/24 Resident #31 had four to five watery stools and was ordered Loperamide two milligrams (mg) every six hours as needed for diarrhea. Resident #31 also complained of nausea and emesis. Laboratory services were ordered on 12/24/24 and were not obtained. Resident #31's pulse ox was 92 percent on room air and the resident's heart rate was 109 (tachycardic). While the NP was visiting, she was alerted Resident #31 had fallen in his room. Resident #31 was trying to walk to bathroom and became dizzy causing a fall. The NP ordered Resident #31 to be sent to the emergency room for evaluation. Review of nurse's note dated 12/27/24 revealed Resident #31 had been admitted to the hospital with acute hypoxic respiratory failure, pneumonia, dehydration, acute kidney injury, and was positive for COVID-19. Review of a hospital note revealed Resident #31 was admitted to the step-down unit on 12/26/24 for acute hypoxic respiratory failure and acute kidney injury. Resident #31 was found to have COVID-19 and pneumonia. Resident #31 had episodes of oxygen desaturation and required oxygen. Resident #31 was treated with Remdesivir, steroids and antibiotics. Remdesivir had to be stopped due to Transaminitis. Resident #31 continued to have intermittent coughing while hospitalized . Review of a NP progress note dated 01/09/25 revealed Resident #31 had readmitted to the facility from the hospital on 01/08/25. Resident #31 was diagnosed with COVID-19, pneumonia, bilateral pulmonary embolism, left leg deep vein thrombosis, and acute kidney injury. Interview on 03/17/25 at 11:27 A.M. with Administrator, Chief Operating Officer (COO) #300, and Registered Nurse/Infection Preventionist (RN/IP) #374 revealed they were unaware Resident #31 had been hospitalized for treatment of COVID-19 and pneumonia after the resident had been symptomatic since 12/06/24. They further confirmed no consents or refusals for vaccines were able to be located for Resident #31. 9. Review of the COVID-19 Vaccination Record Card for Nurse Aid #339 revealed doses of COVID-19 vaccinations were received on 12/23/20, 01/13/21, 02/06/23, and 04/24/23. There was no evidence of facility offering, screening, or education to Nurse Aid #339 for additional doses of COVID-19 vaccination. Interview on 03/20/25 at 8:50 A.M. with the Administrator confirmed she was unable to provide any additional offerings of COVID-19 boosters to Nurse Aid #339 or evidence of any education provided on COVID-19 vaccination.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43063 Based on review of the personnel files, review of the facility assessment and interviews, the facility failed to ensure Certified Nursing Assistants (CNA) #305 and #329 received annual performance reviews. This affected two CNAs of two CNA's personnel files reviewed and had the potential to affect all 54 residents residing in the facility. Findings include: Review of the personnel file for CNA #305 revealed a hire date of 06/03/21. There was no documented evidence that CNA #305 had an annual performance review. Review of the personnel file for CNA #329 revealed a hire date of 06/03/21. There was no documented evidence that CNA #329 had an annual performance review. Interview on 03/18/25 at 3:10 P.M. with the Chief Operating Officer (COO) #300 verified CNAs #305 and #329 did not have an annual performance reviews in their personnel files. Review of the facility assessment dated [DATE], revealed the facility would address areas of weakness as determined in nurse aide performance reviews during training and in-services.