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	05/18/2026

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 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** Based on record review and staff interview, the facility failed to accurately code the preadmission screen and resident review (PASRR) status on the Minimum Data Set (MDS) 3.0 assessment for Residents #7, #13, #18, #25 and #34. This affected five (Residents #7, #13, #18, #25 and #34) of five residents reviewed PASRR. The facility census was 55.Findings Include:1. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, type two diabetes and high cholesterol. Review of the PASRR level two evaluation from the state department of mental health dated 01/23/26 revealed Resident #7 had a level two mental illness.Review of section A of the MDS 3.0 assessment for Resident #7 dated 02/11/26 revealed the facility answered no to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition?2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, type two diabetes and high cholesterol. Review of the PASRR level two evaluation from the state department of mental health dated 03/04/25 revealed Resident #13 had a level two mental illness.Review of section A of the MDS 3.0 assessment for Resident #13 dated 01/27/26 revealed the facility answered no to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition?3. Review of the medical record revealed Resident #18 was admitted to the facility on 10-10/15/25 with diagnoses that included psychosis, mood disorder and major depressive disorder. Review of the PASRR level two evaluation from the state department of mental health dated 01/23/26 revealed Resident #18 had a level two mental illness.Review of section A of the MDS 3.0 assessment for Resident #18 dated 10/28/25 revealed the facility answered no to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition?4. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses that included insomnia, schizophrenia and anxiety disorder. Review of the PASRR level two evaluation from the state department of mental health dated 09/03/25 revealed Resident #25 had a level two mental illness.Review of section A of the MDS 3.0 assessment for Resident #25 dated 10/18/25 revealed the facility answered no to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition?5. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses that included insomnia, major depressive disorder and bipolar disorder. Review of the PASRR level two evaluation from the state department of mental health dated 05/31/25 revealed Resident #34 had a level two mental illness.Review of section A of the MDS 3.0 assessment for Resident #34 dated 06/20/25 revealed the facility answered no to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition?Interview with Director of Social Service (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(DSS) #256 on 05/06/26 at 8:40 A.M. verified the inaccurate coding of Residents #7, #13, #18,#25 and #34's PASRR status on the MDS.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure recommendations from the state Pre-admission Screening and Resident Review (PASRR) authority, the Ohio Department of Mental Health and Addiction Services, were incorporated into residents' comprehensive care plans as required. This affected four (Residents #7, #13, #18, #34) of five residents reviewed for PASRR requirements. The facility census was 55.Findings include:1. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, type II diabetes mellitus, and hyperlipidemia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #7 was severely cognitively impaired, exhibited active delusions, and required supervision with activities of daily living.Review of the PASRR Level II evaluation completed by the Ohio Department of Mental Health and Addiction Services dated 01/23/26 revealed Resident #7 met criteria for serious mental illness and included recommendations for: skills training, speech/language therapy evaluation, structured therapeutic activities, informal support from nursing facility staff, medication evaluation and monitoring by a nursing facility-designated physician, socialization and recreational activities to decrease isolation and improve peer interaction, vision evaluation, physical therapy evaluation, skin/wound evaluation, adaptive equipment evaluation, evaluation for dementia or other organic mental disorder, nutritional consult, neurological examination, dental evaluation, and occupational therapy evaluation.Review of Resident #7's current comprehensive care plan revealed the PASRR Level II recommendations had not been incorporated into the resident's plan of care.2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, type II diabetes mellitus, and hyperlipidemia. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #13 was cognitively intact and required extensive assistance of one staff person for activities of daily living.Review of the PASRR Level II evaluation completed by the Ohio Department of Mental Health and Addiction Services dated 03/04/25 revealed Resident #13 met criteria for serious mental illness. Recommendations included obtaining a comprehensive psychiatric assessment to identify behavioral health supports and services, implementation of a crisis intervention plan, yearly or more frequent psychiatric evaluations to clarify psychiatric diagnoses and appropriate treatment, socialization and recreational activities to decrease isolation and improve mood, respiratory evaluation, skin/wound evaluation, ongoing medication review by a physician, and ongoing evaluation of the effectiveness of psychotropic medications on target symptoms.Review of Resident #13's current comprehensive care plan revealed the PASRR Level II recommendations had not been incorporated into the resident's plan of care.3.Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including psychosis, mood disorder, and major depressive disorder. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #18 was severely cognitively impaired, exhibited active delusions, and required supervision with activities of daily living.Review of the PASRR Level II evaluation completed by the Ohio Department of Mental Health and Addiction Services dated 01/23/26 revealed Resident #18 met criteria for serious mental illness. Recommendations included development of a behavior management safety plan to decrease inappropriate behaviors and ensure safety, yearly or more frequent comprehensive psychiatric evaluations, ongoing evaluation of psychotropic medication effectiveness, ongoing medication review by a psychiatrist or similarly credentialed professional, implementation of a behaviorally-based treatment plan, individual psychotherapy with a trained psychotherapist, and case management services to explore supported community living and assist with transition planning.Review of Resident #18's current comprehensive care plan revealed the PASRR Level II recommendations had not been incorporated into the resident's comprehensive care (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan.4. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses that included insomnia, major depressive disorder and bipolar disorder. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #34 was severely cognitively impaired and required supervision for completing her activities of daily living.Review of the PASRR level two evaluation from the state department of mental health dated 05/31/25 revealed recommendations for treatment that included Crisis intervention plan, A behavior management safety plan to decrease inappropriate behaviors and ensure safety, yearly (or more often) comprehensive psychiatric evaluation to clarify current psychiatric diagnosis and appropriate treatments , ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms, ongoing medication review by a psychiatrist or similarly-credentialed professional ,mental health counseling, behaviorally based treatment plan, individual psychotherapy with a trained psychotherapist.Interview with Director of Social Services (DSS) #256 on 05/06/26 at 8:40 A.M. verified the PASRR Level II recommendations for Residents #7, #13, #18, #34 had not been incorporated into the residents' care plans as required.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview, the facility failed to ensure the environment remained clean, sanitary, hazard-free, and in a state of good repair. This affected 17 (Residents #1, #2, #8, #9, #10, #19, #21, #27, #33, #38, #42, #48, #52, #53, #58, #59, and #61) of 23 residents reviewed for physical environment and had the potential to affect all 55 residents residing in the facility.Findings include:Observation of the laundry area on 05/05/26 at 8:15 A.M. revealed four missing ceiling tiles directly above the area designated for clean clothing storage. The missing tiles exposed overhead structural beams and the open ceiling cavity. Interview with the Administrator during the observation confirmed the ceiling tiles were missing and had not been replaced.An environmental tour was conducted on 05/05/26 between 11:15 A.M. and 11:40 A.M. throughout resident care areas of the facility. The following multiple environmental and maintenance concerns were identified, observed, and verified with the Maintenance Director (MD) #203 at the time of discovery:- The room occupied by Resident #2 contained an electrical outlet missing its protective cover plate, leaving internal wiring components exposed and accessible. - Hallways throughout the facility, all dining room areas, and the rooms occupied by Residents #10, #21, #27, #33, #42, #58, and #59 contained numerous ceiling tiles with visible brown and yellow water stains of varying sizes. Several tiles appeared sagging and discolored, indicating prolonged or repeated water intrusion and lack of repair or replacement.- The privacy curtain utilized by Resident #9 was heavily soiled and contained multiple dark-colored visible stains throughout the fabric. The curtain appeared unclean and poorly maintained within the resident care area.- The floors in the room occupied by Residents #38 and #48 contained multiple unidentified stains and areas of discoloration scattered across the flooring surface. The stains appeared darkened and embedded, giving the flooring an unclean appearance.- The wall adjacent to the doorway in Resident #19's room contained a large visible crack extending vertically along the wall surface. - The interior portion of the ceiling light fixture located in the secured unit shower room contained seven dead insects visible beneath the light covering.- The baseboard heating unit cover located in the secured unit dining area was heavily scuffed, chipped, and deteriorated, with extensive peeling paint observed across the surface.- The ceiling vent located in the secured unit contained a thick accumulation of gray dust buildup covering the vent surface and louvers, indicating the vent had not been adequately cleaned.- Wallpaper in Resident #1's room was visibly peeling and separating away from the wall surface in multiple areas, creating a worn and poorly maintained appearance within the resident living space.- Windows in the rooms occupied by Residents #8, #52, #53, and #61 lacked privacy curtains, limiting the residents' ability to maintain visual privacy within their rooms.This deficiency represents non-compliance investigated under Complaint Number 2722919, Complaint Number 2720286, Complaint Number 2626774 and Complaint Number 2579601.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to ensure residents received proper liability notices that included required information on how to request an immediate appeal of the discontinuation of skilled services. This affected one (Resident #62) of three residents reviewed for beneficiary notices. The facility census was 55.Findings Include:Review of the medical record for Resident #62 revealed the resident received a Notice of Medicare Non-Coverage (NOMNC) dated 11/11/25. Further review of the NOMNC provided to Resident #62 revealed the notice failed to include the name of the Quality Improvement Organization (QIO) and the QIO's telephone number, which are required elements to allow the resident or responsible party to request an immediate appeal. Specifically, under the subsection titled How to ask for an immediate appeal, the notice stated: Call your QIO (Quality Improvement Organization) at (insert QIO name and toll-free number of QIO) to appeal, or if you have questions, indicating the required information had not been completed prior to issuance.Interview with the Administrator on 05/05/26 at 7:40 A.M. confirmed the QIO name and contact information were not included on the NOMNC issued to Resident #62.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** THE FOLLOWING DEFICIENCY REPRESENTED AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on medical record review, review of facility investigations, staff interviews, and review of facility-initiated corrective actions, the facility failed to ensure adequate supervision and interventions were implemented to prevent resident elopement and exit-seeking behaviors. This deficient practice affected three (Residents #4, #47, and #75) of three residents reviewed for elopement risk. The facility census was 55.Findings include:1. Resident #47 was admitted to the facility on [DATE] with diagnoses including personality disorder, bipolar disorder, adjustment disorder, and adult failure to thrive. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and independent with activities of daily living. Psychiatric documentation dated 01/13/25 identified the resident as having severe impairment in judgment and insight. Review of the care plan revealed a history of significant behavioral concerns including refusal of care and medications, aggression, destruction of property, and verbal aggression toward staff.Review of nursing documentation dated 06/12/25 at 1:34 A.M. revealed staff entered Resident #47's room to administer medications and discovered the resident missing from the room with shattered glass from a broken window present. Staff confirmed the resident was not located within the room or adjoining bathroom area. Review of the facility investigation revealed the resident had last been observed at approximately 10:00 P.M. on 06/11/25 following care provided by staff. At approximately 10:45 P.M., nursing staff identified the broken window and initiated a search of the facility and surrounding grounds. The resident was ultimately located approximately one mile away from the facility and was returned to the building by local law enforcement before being transported to the emergency room for evaluation. Interview with the Administrator on 05/05/26 at 8:45 A.M. verified the circumstances surrounding the elopement incident.As a result of the incident, the facility implemented the following corrective actions by 06/12/25:- On 06/11/25 at 11:00 P.M., the police were notified that Resident #47 was missing.- On 06/11/25 at 11:05 P.M., a facility-wide resident head count was completed, and no additional missing residents were identified.- On 06/11/25 at 11:15 P.M., staff located the resident approximately one mile from the facility.- On 06/11/25 at 11:20 P.M. Licensed Practical Nurse (LPN) #223 accompanied the police back to the facility with Resident #47, and Resident #47 was transported to the emergency room for evaluation.- On 06/12/25 at 7:00 A.M. Resident #47 returned to the facility. Resident #47 was moved to a temporary room with one-on-one supervision until a bed on the facilities secured unit became available.- On 06/12/25 at 7:00 A.M. a scheduled staff meeting was held regarding the facilities policies and procedures for resident elopement.- On 06/12/25 at 8:30 A.M. the facilities Administrator attempted to interview Resident #47, however Resident #47 refused the interview, stating he only wanted his television and his bed.- On 06/12/25 at 9:00 A.M. Resident #47 was seen by the facilities Nurse Practitioner (NP).- On 06/12/25 at 9:30 A.M. Resident #47 was placed on the facilities secured unit with window opening through the secured courtyard area for added security. Every 15-minute checks were also initiated.- On 06/12/25 at 10:00 A.M. the Assistant Director of Nursing (ADON) #900 began completing elopement assessments on all residents including Resident #47. Upon completion of assessments the facilities elopement binder (book used to identify residents with high elopement risk) was updated.- On 06/12/25 at 10:00 A.M. the Director of Social Services (DSS) #256 notified all residents' responsible parties of the facilities sign in and sign out procedures.- On 06/12/25 at 11:00 A.M. a second scheduled staff meeting was held other staff who could not attend the earlier meeting for elopement education.- On 06/12/25 at 1:00 P.M. an elopement drill was conducted.- On 06/12/25 at 1:30 P.M. the Director of Maintenance (DM) #500 audited each window ensuring that each window opened to a maximum of six inches.- On 06/12/25 at 2:00 P.M. the DM # (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	500 inspected all exit doors and ensured alarms were in working order.- On 06/12/25 at 2:30 P.M. a quality assurance and performance improvement (QAPI) meeting was held with root cause analysis completed.- On 06/12/25 at 4:00 P.M. another staff meeting was held with all staff members regarding elopement education.- On 06/12/25 between 6:00 P.M. and 8:00 P.M. telephone education was provided by the Administrator and Human Resources Director for those who could not attend the earlier elopement educations.2. Resident #75 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury, alcohol dependence, and history of suicidal behaviors. Review of the most recent MDS assessment dated [DATE] revealed the resident was cognitively intact and independent with activities of daily living. Care plan documentation identified concerns related to impulsive behaviors and anxiety, while psychiatric documentation dated 07/07/25 identified ongoing impulsivity and safety concerns.Review of the facility timeline revealed that on 07/27/25 at approximately 9:00 P.M., Licensed Practical Nurse (LPN) #223 responded to the facility front entrance after hearing the doorbell and discovered a wheelchair positioned outside the entrance with the resident's name labeled on the chair. Staff immediately checked the resident's room and determined the resident was missing from the facility. At approximately 10:04 P.M., police located the resident approximately one-half mile from the facility and escorted him safely back to the building. During staff interview following the incident, the resident stated he had been able to leave the building because he knew the facility door access code. Interview with the Administrator on 05/06/26 at 9:30 A.M. verified the resident eloped from the facility.As a result of the incident, the facility implemented the following corrective actions by 07/28/25:- On 07/27/25 at 9:05 P.M. a head count of all residents was completed with no other missing residents.- On 07/27/25 at 10:05 P.M. the Director of Nursing (DON) arrived on site and completed and an assessment of Resident #75 with no noted concerns.- On 07/27/25 at 10:15 P.M. paramedics arrived at the facility and did not transport the resident to a hospital as they deemed the situation not an emergency situation.- On 07/28/25 at 8:30 A.M. the Administrator interviewed Resident #75. He confirmed that he knew the code to the door and was able to open the door using that code.- On 07/28/25 at 9:00 A.M. a QAPI meeting was held to develop a root cause analysis for the situation.- On 07/28/25 at 9:15 A.M. all doors that required numerical code input were changed.- On 07/28/25 at 10:00 A.M. at 10:00 A.M. Resident #75's care plan was updated to reflect an elopement risk.- On 07/28/25 at 11:00 A.M. elopement assessments were completed on all residents including Resident #75.- On 07/28/25 at 11:30 A.M. the facilities elopement binder was reviewed and updated.- On 07/28/25 at 12:00 P.M. Resident #75 was seen by the facilities NP.- On 07/28/25 at 12:30 P.M. an elopement drill was conducted.- On 07/28/25 at 1:15 P.M. all staff present were educated about the facilities elopement policy and procedure and responsibility for maintaining door code security.- On 07/28/25 between 2:00 P.M. and 4:00 P.M. staff not at facility were contacted via phone and educated on the facilities' elopement policy and procedure and responsibility for maintaining door code security.3. Resident #4 was admitted to the facility on [DATE] with diagnoses including brain cancer, hallucinogen use, and epilepsy. Review of the most recent MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired and independent with activities of daily living. Care plan documentation identified poor impulse control.Review of nursing documentation dated 02/12/26 at 6:17 P.M. revealed the resident demonstrated repeated exit-seeking behaviors, including approaching and exiting through the facility front entrance, causing activation of the door alarm on multiple occasions. Staff responded immediately each time the alarm activated and observed the resident outside the facility near the entrance area while remaining within direct staff observation. Staff provided verbal redirection and safely escorted the resident back into the building without resistance. Nursing staff completed assessments, obtained vital signs, and documented no evidence of injury, pain, or acute distress. Nursing administration and the attending provider were notified of the incidents, and due to continued wandering and exit-seeking behaviors, the facility implemented increased supervision interventions including continuous one-to-one observation. Interview with the Administrator on 05/06/26 at 9:30 A.M. verified Resident #4's exit-seeking (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors and related incident.The deficient practice was corrected on 02/13/26 when the facility implemented the following corrective actions: - On 02/12/26 at 6:15 P.M., a call was placed to the DON and NP notifying of the incident. The NP gave orders for intramuscular (IM) Haldol (antipsychotic) injection which was refused by the resident. A message was left for Resident #4's guardian. - On 02/12/26 at 6:30 P.M., the local police arrived at facility following call from an unknown source while Resident #4 was near the road. Police ensured/confirmed safety of the resident. - On 02/12/26 at 6:40 P.M., a head count was completed by LPN #400- On 02/12/26 at 8:05 P.M., Resident #4 went to front doors and again pushed the handle allowing alarm to sound. LPN #400 heard alarm and approached the front door. She witnessed the doors release and Resident #4 proceed outside of doors. LPN #400 followed him out and after reassurance was able to redirect him back inside. - On 02/12/26 at 8:20 P.M., a call was placed to the DON and NP. Orders given for emergency transfer. Resident #4's guardian was notified of change in condition and new orders. - On 02/12/26 at 8:25 PM Head count was completed by LPN #400.- On 02/12/26 at 8:25 P.M., Resident #4 left the facility via ambulance and was taken to the local hospital.- On 2/13/26 at 9:00 A.M., a QAPI meeting was held to discuss the incident-root cause analysis determined exacerbation of psychiatric conditions causing increased behaviors in Resident #4.- On 02/13/26 at 9:15 A.M. Resident #4's care plan reviewed and updated. - On 02/13/26 at 10:00 A.M., an elopement drill was conducted.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident and staff interviews, and facility policy review, the facility failed to identify and incorporate known post-traumatic stress disorder (PTSD) triggers into the care plan to prevent reˆtraumatization for one (Resident #40) of one resident reviewed for trauma-informed care. The facility census was 55.Findings include:Record review showed Resident #40 was admitted on [DATE] with diagnoses including bipolar disorder, major depressive disorder, and PTSD. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 10/15, indicating moderate cognitive impairment. The resident received Prazosin z(alpha blocker used to treat nightmares related to PTSD) 2 milligrams (mg) nightly for PTSD.The resident's psychosocial evaluation dated 8/14/24 also documented a history of being mauled by pit [NAME]. However, review of the resident's mood-focused care plan showed no inclusion of this identified trigger and no interventions to prevent exposure to dogs during facility activities. Review of the initial psychiatry initial consult dated 11/11/24 and ongoing psychotherapy notes (dated 10/15/25 through 04/08/26) identified a specific PTSD trigger: Resident #40 was attacked by three pit [NAME] in childhood and continued to experience flashbacks related to this event. Interview on 05/05/26 at 2:55 P.M. with Director of Social Services (DSS) #256 and the Resident Review Nurse (RRN) #266 confirmed that Resident #40's PTSD trigger was not careˆplanned.During an interview on 05/05/26 at 4:00 P.M., Resident #40 stated he did not like dogs and felt bothered when therapy dogs visited. He reported staff did not keep the dogs away from him. Interview on 5/12/26 at 1:44 P.M. with Activity Director (AD) #226 revealed Resident #40 enjoyed religious activities, snack socials, live music, and pets. The facility had a musician visit once a month with two therapy dogs. The dogs stayed with the musician during the activity. Resident #40 informed AD #226 that he was bitten by dogs when he was a child. Resident #40 had attended the music activities when the dogs were present, and she informed the resident prior to the activity. She stated she had observed Resident #40 pet the dogs on occasion.Observations on 05/04/26, 05/05/26, 05/06/26, 05/07/26, 05/11/26, and 05/12/26 revealed no dogs in the building.Review of the facility's Resident Care Plans policy (05/01/22) stated that care plan interventions must address underlying sources of problems, not only symptoms or triggers.