STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365595	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Franklin	421 Mission Lane Franklin, OH 45005

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observations, staff and resident interviews and policy review, the facility failed to ensure medications were stored securely. This affected five (#18, #29, #32, #55 and #56) out of five residents reviewed for medication storage. This had the potential to affect four (#29, #48, #10 and #57) residents that the facility identified as cognitively impaired and independently mobile. The facility census was 61. Findings include: 1. Medical record review for Resident #18 revealed an admission on [DATE] with diagnoses including but not limited to schizophrenia, left female breast cancer, anxiety disorder, impaired cognition and bipolar disorder. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] for Resident #18 revealed an intact cognition. Resident #18 was independent for eating and supervised toileting, bed mobility, and transfers. Resident #18 was incontinent of bowel and bladder. Resident #18 was receiving hospice services. Review of the plan of care for Resident #18 revealed resident remains at risk for skin breakdown due to medical conditions. Previously closed area on coccyx has reopened and nurse practitioner will follow and as needed. Interventions include body audits as scheduled, monitor labs, monitor pain symptoms, reposition every two hours, and wound nurse weekly. Review of the active physician orders for [DATE] for Resident #18 revealed an order dated [DATE] for a low air loss mattress to bed, an order dated [DATE] to cleanse coccyx with normal saline. Pat dry. Apply triad cream three times a week and as needed. Hospice to perform two times a week and facility staff to perform one time a week and as needed. Hospice to perform care on Monday and Wednesday. Review of the discontinued physician orders for Resident #18 revealed an order dated [DATE] and discontinued on [DATE] for cleanse open area to coccyx with normal saline, pat day, pack with calcium alginate and cover with silicone sterile adhesive dressing. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 4:13 P.M. of Resident #18 bedside stand revealed one spray bottle of Integrity wound cleaner with a warning on the label if swallowed seek medical attention, a second wound cleanser bottle, a box of comfort foam dressings, an open package of calcium alginate wound dressing and a hydrophilic wound dressing unsupervised. Interview on [DATE] at 4:19 P.M. with Assistant Director of Nursing (ADON) #69 verified the observation and stated the wound cleansing products should not be in the room. 2. Medical record review for Resident #29 revealed an admission on [DATE] with diagnoses including but not limited to hemiplegia and hemiparesis following a stroke, peripheral vascular disease, dementia, convulsions, major depression disorder, hypothyroidism, vascular dementia, and hypertension. Review of the quarterly MDS assessment dated [DATE] for Resident #29 revealed was unable to complete the brief interview for mental status with staff interview revealing modified independence. Resident #29 was coded as independent with eating. Resident #29 required maximum assistance for toileting, bed mobility and transfers. Review of the active physician orders for Resident #29 revealed an order dated [DATE] for Norco oral tablet , d+[DATE] mg one tablet every 12 hours for pain related to headache and an order dated [DATE] for Senna 8. 8 mg two tablets every 12 hours for constipation. Observation on [DATE] at 8:42 A.M. of Resident #29 revealed a bottle of nystatin powder on bedside in resident's room. Further observation of the pharmacy label revealed it was ordered for Resident #30. Interview on [DATE] at the time of observation with LPN #36 verified that the bottle of nystatin powder was for Resident #30 and should not be in the room. 3. Medical record review for Resident #32 revealed an admitted d on [DATE] with diagnoses including but not limited to encephalopathy, epilepsy atherosclerotic heart disease of native coronary artery, hemiplegia and hemiparesis following a stroke affecting the left non dominant side, major depressive disorder, retention, hypertension and pain. Review of the Admission MDS assessment dated [DATE] revealed resident #32 had intact cognition. Resident #32 was coded as independent with eating, maximal assistance with toileting, supervision for bed mobility and moderate assistance with transfers. Observation on [DATE] at 9:06 A.M. revealed LPN #36 prepared the oral medication for Resident #32. Medication including Baclofen 20 mg one tablet, Eliquis tab 5 mg one tablet, Aspirin 81 chewable one tablet, Atenolol 25 mg one tablet, Famotidine 20 mg one tablet, Folic acid 1 mg one tablet, Gabapentin 300 mg one tablet, Levetiracetam 1000 mg one tablet, Omeprazole 40 mg tab one tablet and Vitamin B12 100 mg one tablet. LPN #36 carried the medication into the room and set it on the bedside table in front of Resident #32. LPN #36 then left the room to ensure there was not any blood pressure parameters related to scheduled medication. Additional observation on [DATE] at 9:16 A.M. of Resident #32's bedside table revealed two large tubes of Voltaren topical ointment. Further observation revealed one tube did not have a label and the other tube had a label from the hospital prior to admission. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 9:16 A.M. with Resident #32 stated the hospital gave one tube to him and he brought it with him when he transferred and has been on that table since arrival. Interview on [DATE] at 9:25 A.M. with LPN #36 verified she left the prepared medication in the residents 'room unsupervised and should not have. LPN #36 verified that Resident #32 did not have orders for the Voltaren topical ointment and stated it should not have been in his room. 4. Medical record review for Resident #55 revealed an admission on [DATE] with diagnoses including but not limited to heart disease, ventricular tachycardia, extended spectrum Beta Lactamase resistance, chronic kidney disease stage three, hypertension, chest pain, chronic embolism and thrombosis, spinal stenosis. Review of the quarterly MDS assessment dated [DATE] for Resident #55 revealed an intact cognition. Resident #55 is independent for eating and bed mobility. Resident #55 requires supervision for transfers and toileting. Observation on [DATE] at 9:40 A.M. of Resident #55 bedside table revealed two bottles of Nasal spray oxymetazoline hydrochloride 0.05% with expired dates of ,d+[DATE] and ,d+[DATE]. Interview on [DATE] at 9:48 A.M. with LPN #55 verified Resident #55 did not have orders for the medications and stated they should not be in his room unsupervised. 5. Medical record review for Resident #56 revealed an admission on [DATE] with diagnoses including but not limited to heart disease, chronic kidney disease, hypertension and major depressive disorder. Review of the comprehensive MDS assessment dated [DATE] for Resident #56 revealed an intact cognition. Resident #56 was coded as independent for eating, bed mobility, transfers. Resident #56 required moderate assistance with toileting. Observation on [DATE] at 10:00 A.M. from the hallway into Resident #56's room revealed a bookshelf with three bottles on it. Further observation with LPN #55 revealed one opened bottle of hydrogen peroxide, a nasal spray bottle (oxymetazoline hydrochloride 0.05%) and an opened bottle of acetone fingernail polish removed. The bottles of hydrogen peroxide and the acetone both had warning labels to contact medical services if ingested. Interview on [DATE] at the time of the observation with LPN #55 verified the items noted should not be in the residents' room and removed them. 6. Observation on [DATE] at 10:35 A.M. of the four-drawer treatment cart located on the 300 hundred hall was unlocked and unsupervised. Observation on [DATE] at 10:35 A.M. with LPN #55 and the Administrator verified the cart contained treatment supplies, topical creams and ointments and bottles of hydrogen peroxide and dyna hex with label to contact poison control if ingested. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 10:35 A.M. with LPN #55 and the Administrator verified the treatment cart contained medical supplies with warning labels to contact the poison control center if ingested and should have not been unlocked and unsupervised. The facility confirmed there were four (#29, #48, #10 and #57) residents that are cognitive impaired and independently mobile that could access unsecured medications. Review of the facility policy titled Medication Storage dated [DATE] states the facility shall store all drugs and biological's in a safe, secure and orderly manner. Number 7 states compartments including but not limited to drawers, cabinets, room, carts containing drugs ad biological shall be locked when not in use and shall not be left unattended. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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 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. 39967 Based on observation, staff interview, review of the facility menu and spreadsheet and policy review, the facility failed to ensure menus were followed. This had the potential to affect 59 of 59 residents who receive their meals from the kitchen, the facility identified two residents (#25 and #31) that received no food by mouth. The facility census was 61. Findings include: Review of the menu dated 07/03/24 revealed oatmeal or cold cereal, cheesy scrambled eggs, a sausage patty, assorted toast, whole milk or two percent milk and coffee or tea were to be served for breakfast. Review of the undated menu spreadsheet revealed regular diets were to receive six ounces of oatmeal, two ounces of cheesy scrambled eggs, and one slice of toast for breakfast, mechanical soft diets were to receive six ounces of oatmeal, two ounces of cheesy scrambled eggs, and one slice of toast for breakfast and pureed diets were to receive six ounces of pureed oatmeal, two ounces of pureed cheesy scrambled eggs, and two ounces of pureed toast for breakfast. Observation of the kitchen on 07/03/24 at 7:38 A.M. revealed [NAME] #65 took the temperature of the food on the tray line. The oatmeal was 160 degrees Fahrenheit, the ham was 145 degrees Fahrenheit, the mechanical ham was 180 degrees Fahrenheit, the pureed sausage was 160 degrees Fahrenheit, and the scrambled eggs were 140 degrees Fahrenheit. [NAME] #65 was observed to serve regular diets six ounces of oatmeal, one slice of ham and one slice of toast, mechanical soft diets six ounces of oatmeal, two ounces of mechanical ham and one slice of toast and pureed diets six ounces of oatmeal, four ounces of pureed scrambled eggs and four ounces of pureed sausage. Interview with [NAME] #65 on 07/03/24 at 7:38 A.M. verified regular diets were served six ounces of oatmeal, one slice of ham and one slice of toast, and mechanical soft diets were served six ounces of oatmeal, two ounces of mechanical ham and one slice of toast. [NAME] #65 verified regular and mechanical soft diets did not receive cheesy scrambled eggs per the menu spreadsheet and the facility did not provide regular or mechanical soft diets a substitution for the cheesy scrambled eggs. [NAME] #65 also verified pureed diets received six ounces of oatmeal, four ounces of pureed scrambled eggs and four ounces of pureed sausage and pureed diets did not receive pureed bread per the menu spreadsheet. [NAME] #65 stated that ham was provided to residents that received regular and mechanical soft diets as a substitution for sausage because the facility was out of sausage. Review of the nutritional services policy dated 05/01/22 revealed food portion sizes will be reviewed by the dietician on an as needed basis to ensure nutritional needs are met. This deficiency represents non-compliance investigated under Complaint Number OH00155177.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39967 Based on observation, staff interview, record review, the facility failed to ensure food items were stored in a sanitary manner. This had the potential to affect 59 of 59 residents who receive their meals from the kitchen, the facility identified two residents (#25 and #31) that received no food by mouth. The facility census was 61. Findings include: Observation of the kitchen on 07/03/24 at 7:45 A.M. revealed the reach in refrigerator in the kitchen was 60 degrees Fahrenheit. A package of ham, a package of hamburgers and a package of hotdog's were located in the refrigerator. There was also a gray fuzzy substance on the line that went from the ceiling to the steam table and there was a gray fuzzy on the ceiling vent located directly above the onions in the dry storage room. There were also three flies sitting on the line that went from the ceiling to the steam table in the kitchen. Interview with Dietary Supervisor (DS) #110 on 07/03/24 at 7:45 A.M. verified the reach in refrigerator was 60 degrees Fahrenheit and there was a package of ham, a package of hamburgers and a package of hotdog's located in the refrigerator. DS #110 stated the refrigerator had been broken approximately one week. DS #110 also verified there was a gray fuzzy substance on the line that went from the ceiling to the steam table and there was a gray fuzzy on the ceiling vent located directly above the onions in the dry storage room. DS #110 confirmed there were three flies sitting on the line that went from the ceiling to the steam table in the kitchen. Review of the facility's preventing foodborne illness policy dated 05/01/22 revealed food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. The policy stated federal standards require that refrigerated food be stored below 41 degrees Fahrenheit. This deficiency represents non-compliance investigated under Complaint Number OH00155177.

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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 - Few	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** 39702 Based on medical record review and staff interviews, the facility failed to ensure a resident's admission assessments were timely completed in the electronic health record. This affected one (#300) out of three residents reviewed for medical record accuracy and completeness. The facility census was 61. Findings include: Medical record review for Resident #300's chart revealed resident admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, emphysema, congestive heart failure, chronic kidney disease and hypertension. Resident #300 discharged from the facility on 05/23/24 at approximately 9:49 A.M. Review of Resident #300's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #300 was independent with eating. Resident #300 required maximal assistance with toileting, showering, lower body dressing, sitting to lying, lying to sitting, sitting to standing, chair transfers, toilet transfers, tub transfers, and walking ten feet. Resident #300 required moderate assistance with upper body dressing, personal hygiene, rolling left and right. Resident #300 was coded as always incontinent of bladder and occasionally incontinent of bowel. Resident #300 had two stage two pressure ulcers that were present on admission. Review of the plan of care for Resident #300 revealed the document was not completed. Review of the Nursing Admission Assessment with Care Plan for Resident #300 revealed the assessment was opened in the electronic health record on 05/16/24 but wasn't marked as completed until 05/23/24 at 11:59 A.M. which was after the resident was discharged . The assessment was completed by the Administrator/Licensed Practical Nurse (LPN) #100. Further review of the assessment revealed the two pressure ulcers were not documented on the skin assessment only bruising on both right and left hands. Review of the Bowel and Bladder Assessment for Resident #300 revealed the assessment was opened on 05/17/24 and completed on 05/23/24 at 10:55 A.M. after the resident was discharged by Registered Nurse (RN) #804. Review of the Braden scale for Resident #300 revealed the assessment was opened on 05/17/24 at 10:56 A. M. and completed on 05/23/24 at 10:57 A.M. after the resident was discharged by RN #804. Review of the dental oral evaluation for Resident #300 revealed the assessment was opened on 05/17/24 at 10:58 P.M. and completed on 05/23/24 at 10:59 A.M. after the resident was discharged by RN #804. Review of the pain tool for Resident #300 revealed the assessment was opened on 05/17/24 at 11:02 A.M. and closed on 05/23/24 at 11:09 A.M. after the resident was discharged by RN #804. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weekly Head to Toe assessment for Resident #300 revealed the assessment was opened on 05/16/24 at 12:00 P.M. and completed on 05/23/24 at 11:25 A.M. after the resident was discharged . Review of the falls assessment for Resident #300 revealed the assessment was opened on 05/17/24 and completed on 05/23/24 by RN #804. Interview on 07/10/24 at 12:59 P.M. with RN #804 verified she was the Director of Nursing (DON) for a sister facility and helping at this facility due to having an Intern DON at the facility. RN #804 verified the assessments were not documented as completed until after Resident #300 had left the facility. Interview on 07/10/24 at 3:05 P.M. with the Corporate RN #800 stated the facility did not have a policy regarding the documentation or completion of the admission assessments. Interview on 07/11/24 at 11:37 P.M. with the Administrator verified the admission assessments were completed/locked after Resident #300 was discharge and further verified that it was the expectation of the facility to have the admission assessments (bowel and bladder assessment, Braden assessment, fall assessment, pain assessment, dental assessment and elopement assessment) completed on the day of admission. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observations, staff interviews and policy review, the facility failed to ensure staff completed hand hygiene during during incontinence care. This affected one (#06) out of three residents reviewed for incontinent care. The facility census was 61. Findings include Medical record review for Resident #06's revealed resident was admitted to the facility on [DATE] with diagnoses including unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, hyperlipidemia, retention of urine, hypertension, anxiety disorder, peripheral vascular disease, muscle weakness and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #06 revealed the resident had severe cognitive impairment. Resident #06 required supervision with eating and rolling left and right. Resident #06 required moderate assistance with toileting, personal hygiene, and maximal assistance with toileting. Resident #06 was coded as being incontinent of bladder and bowel. Observation on 07/09/24 at 3:34 P.M. with State tested Nursing Assistant (STNA) #40 and #87 providing incontinent care for Resident #06. Resident #06 was assisted into the shower room. STNA #40 applied gloves to both hands and assisted the resident to pull down his sweatpants. Resident #06 was sitting on the commode when STNA #40 removed his incontinent brief that was saturated with urine. STNA #40 folded the brief up and placed it into the trash container. STNA #40 then removed his sweatpants and pulled up his gripper socks up. STNA #40 placed each leg into the new sweatpants and the applied the tabbed brief to Resident #06 around his upper thighs. Resident #06 stated he was done with the toileting and STNA #40 pulled an incontinent wipe from a package. Resident #06 was assisted to a standing position utilizing the garb bar. STNA #40 used one wipe to complete four passes to the perineal area without using a separate area for each stroke from front of the perineal to the back of the perineal area and then discarded the wipe into the trach container. STNA #40 then pulled up the incontinent brief and then the sweatpants. Resident #06 was assisted back into the wheelchair. STNA #40 then moved the wheelchair out of the bathroom using the handle grips with gloved hands and positioned him into the shower area. STNA #40 removed the package of wipes from the bathroom and placed them on a cabinet in the shower area. STNA #40 then went into the bathroom, removed her gloves and placed them in the trash container. STNA #40 then exited the bathroom, placed her hands on the wheelchair handles and pushed the resident out into the hallway. Interview on 07/10/24 at 3:45 P.M. STNA #40 verified she did not wash her hands after removing the urine-soaked brief and should have. STNA #40 verified she used the contaminated gloves to push the resident into the shower area. Additionally, STNA #40 verified when she did remove the gloves she did not complete hand hygiene, handling the wheelchair handle grips, the package of wipes and the doorknob to get out of the shower room. Interview on 07/11/24 at 4:15 P.M. with the Corporate Registered Nurse (RN) #800 verified the staff should be washing her hands when she removes her gloves each time during incontinent care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Peri Care, dated 05/01/22, states under #11 to use a clean area of cloth for each area cleaned, Number 13 states remove gloves and perform hand hygiene and apply clean gloves to apply clean brief and reapply clothing. This deficiency is based on incidental findings discovered during the course of this complaint investigation.