

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2025
NAME OF PROVIDER OR SUPPLIER Momentous Health at Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE 421 Mission Lane Franklin, OH 45005	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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** Based on record review, observations, resident and staff interviews, review of dietary spreadsheets, review of guidelines for pureeing food, and policy review, the facility failed to ensure residents received enough food to meet their needs and preferences, serve portions sizes as planned on the menu, ensure pureed food was prepared in a manner to maintain the nutritive value of the food, and ensure posted menus were updated for the residents to view what meals they were having for the day. This affected Resident #3 and had the potential to affect 65 of 66 residents. The facility identified one resident (#9) who did not receive food from the kitchen. The facility census was 66. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 05/21/25. Diagnoses included type II diabetes mellitus, end-stage renal disease (ESRD) with dependence on renal dialysis, and gastroesophageal reflux disease. Review of the nutrition care plan dated 05/23/25 revealed Resident #3 was on a restricted diet due to ESRD with interventions of provide diet as ordered and communicate with the renal registered dietician (RD) as needed. There was no interventions listed to address Resident #3 not receiving enough food and addressing Resident #3's behavior to eat off other resident's used food trays. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had moderately impaired cognition. Interview on 09/08/25 at 12:05 P.M., Resident #3 stated he was supposed to receive a renal diet and sometimes he does not get enough food to eat. Resident #3 stated he was supposed to get double portions. Observation on 09/10/25 at 8:22 A.M. revealed Resident #3 was pulling food off of used food trays on the food services cart. Resident #3 was eating the food items pulled off the cart. Interview on 09/09/25 at 8:24 A.M. with Licensed Practical Nurse (LPN) #151 confirmed Resident #3 was pulling and eating food off the used breakfast trays located on the food services cart. LPN #151 stated Resident #3 pulls food off the dirty food trays on the food services cart all the time and eats it. LPN #151 confirmed the facility hasn't stopped Resident #03 from eating food off the dirty trays stating you can't stop him we just let him do it. Review of the Meal Delivery policy dated 05/01/22 revealed nursing staff collects all the trays from the resident's rooms and places them back into the mobile trucks after mealtime, then the cart is returned to the Dietary Department. (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the dietary spreadsheet, dated 09/09/25 revealed two beef tacos, each containing a #16 (2 ounce) scoop of meat in each, were to be served. Observation on 09/09/25 from 11:53 A.M. to 12:29 P.M. of tray line for the lunch meal revealed [NAME] #166 placed one taco (one flour tortilla containing 2 ounces of taco meat) on each plate. Continued observation revealed [NAME] #166 provided two tacos for residents who were supposed to receive double portions. At 12:03 P.M., a cart containing trays for the dining room left the kitchen. At 12:14 P.M., a cart containing trays for the 100 hall left the kitchen. At 12:28 P.M., a cart containing trays for the 300 hall left the kitchen. Interview on 09/09/25 at 11:53 A.M., [NAME] #166 stated residents who received the standard menu were served one taco and residents on double portions were served two tacos. Interview on 09/09/25 at 12:29 P.M. Dietary Supervisor #168 verified the portion size for the tacos was supposed to be two tacos and residents on double portions should have received four tacos. Review of the facility policy titled Portion Control dated 2010 revealed residents would receive the appropriate portions of food as planned on the menu. 3. Observation on 09/09/25 at 10:43 A.M., [NAME] #166 stated there were five residents on pureed diets. [NAME] #166 added five scoops of taco meat to the food processor, then added approximately 6 ounces of beef broth. [NAME] #166 then started the food processor and added approximately half cup of bread crumbs and continued pulsing. [NAME] #166 turned the food processor off and checked the consistency of the mixture, and stated it was more runny than he preferred, added more bread crumbs, and started the food processor again. Interview on 09/09/25 at 10:58 A.M., [NAME] #166 verified he added liquid to the processor before assessing the need to add liquid. When queried regarding the use of a recipe for making pureed food, [NAME] #166 stated, that's how I make it. That's my recipe. Interview on 09/09/25 at 1:18 P.M., DS #168 verified the guidelines for making pureed food indicated the appropriate procedure was to place the food in the food processor, puree, and then assess the need to add more water or thickening agent. Review of the facility policy titled Pureed Food Preparation dated 2009 revealed food should be placed in the processor bowl, drained of liquid, and pureed well. The addition of fluid may not be necessary, depending on product composition. 4. Observation on 09/08/25 at 9:09 A.M. revealed the menu posted in the 200 hall was for Friday, 09/05/25. Observation on 09/08/25 at 9:10 A.M., Resident #39 looked at the posted menu on the 200 hall and stated, that doesn't do me any good. That's from several days ago. Interview on 09/08/25 at 9:10 A.M., Certified Nursing Assistant (CNA) #116 verified the menu posted on the 200 hall was from 09/05/25, three days prior. Interview on 09/11/25 at approximately 8:00 A.M., Dietary Supervisor (DS) #168 stated she or the cook is responsible for posting the daily menus. DS #168 stated she was unable to get menus printed (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	over the weekend and was not able to update the posted menu until Monday morning. The facility identified Resident #9 did not receive food from the kitchen.		

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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. Based on observation, resident and resident representative interviews, and staff interview, the facility failed to ensure residents received foods that were palatable. This had the potential to affect 65 of 66 residents. The facility identified one resident (#9) who did not receive food from the kitchen. The facility census was 66. Findings include: Review of a test tray on 09/09/25 at 12:52 P.M. with Dietary Supervisor (DS) #168, revealed the taco, refried beans, and rice and beans were luke warm and not palatable. DS #168 verified the taco, refried beans, and rice and beans were not served at a suitable temperature and were not palatable. Interview on 09/09/25 at 1:07 P.M., Resident #39 stated the food he was served for lunch was cold. Interview on 09/09/25 at 1:11 P.M., Resident #20 stated the food she was served for lunch was cold, like it always is. The resident described the food as hog slop. Interview on 09/08/25 at 9:10 A.M., Resident #77 complained of the food being cold. Interview on 09/08/25 at 10:03 A.M., Resident #24's responsible party stated Resident #24 often complained about the food being cold. The facility identified Resident #9 did not receive food from the kitchen. This deficiency represents non-compliance investigated under Complaint Number OH00165869 (1260837).		

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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. Based on observation, staff interview, and policy review, the facility failed to ensure food was stored in a manner to protect against the potential spread of foodborne illness. The facility also failed to ensure staff wore hair restraints in the kitchen. The facility also failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect 65 of 66 residents in the facility. The facility identified one resident (#09) who did not receive food from the kitchen. The facility census was 66. Findings include: Observation and interview on 09/08/25 at 7:50 A.M. of the kitchen's reach-in refrigerators with Dietary Supervisor (DS) #168 revealed a reusable plastic bag of cheese slices that was unsealed, and a package of bologna slices not dated or sealed. There was also a box containing two bags of sausage and one of the bags was not sealed and did not have a date. DS #168 verified the cheese was not sealed and the bologna and sausage were not sealed or dated. DS #168 verified all food should be sealed and dated. Observation and interview on 09/08/25 at 8:00 A.M. with DS #168 revealed a bag of cookie dough which was not sealed and two plastic disposable cups containing an unidentified food, which were not sealed, labeled, nor dated. DS #168 verified the cookie dough was not sealed and the two plastic cups were not sealed, labeled, or dated. Observation and interview on 09/09/25 at 10:43 A.M. revealed [NAME] #166 preparing pureed taco meat. [NAME] #166 had facial hair, measuring approximately one-fourth inch, and was not wearing any type of restraint for his facial hair. At 11:09 A.M., [NAME] #166 verified he was not wearing a hair restraint for his facial hair. Observation and interview on 09/09/25 at 11:03 A.M. with DS #168 revealed there was a round vent on the ceiling above the steam table. The vent was coated in light brown debris and there were black specs on the ceiling in the surrounding four foot area which were flapping in the breeze from the vent. The support beam for the steam table, which extended to the ceiling of the kitchen revealed the top-most portion, measuring approximately two feet, was coated in a brown and grey fuzzy substance. DS #168 verified the vent was coated in light brown debris and black specs surrounded the four foot area around the vent. DS #168 verified the support beam was coated in a brown and grey fuzzy substance. DS #168 verified the areas needed to be cleaned and stated she was unable to reach the areas. DS #168 was standing next to [NAME] #166 while [NAME] #166 was preparing food for the lunch meal. DS #168 was wearing a hair net, however her hair was not fully covered, and approximately three inches of hair was sticking out from under the hair net around the head. DS #168 verified her hair was not fully contained by the hairnet. Review of the facility's undated policy titled Food Safety and Sanitation revealed hair restraints are required and should cover all hair on the head and beard nets are required when facial hair is visible. Food should be protected from contamination (including dust). All time and temperature control for safety (TCS) foods should be labeled, covered, and dated when stored. When a food package is opened, the food item should be marked to indicate the open date, which is used to determine when to discard the food.		

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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 Based on review of the facility's quality assurance performance improvement (QAPI) meeting sign-in sheets, review of the facility's QAPI meetings policy, and staff interview, the facility failed to ensure required QAPI team member were present at meetings. The had the ability to affect all 66 residents residing in the facility. Findings include: Review of the facilities' QAPI/Quality Assessment and Assurance (QAA) meeting sign in sheets revealed the following: The Director of Nursing (DON) and Medical Director (MD) were not present at a meeting 10/23/24. No designees for the DON or MD were listed. The DON and MD were not present at a meeting dated 02/10/25. No designees for the DON or MD were listed. No staff identified as the infection preventionist (IP) or designee was present. No designee for the IP listed. The DON was not present at a meeting dated 04/22/25. No designee for the DON was listed. The IP was not present at a meeting dated 08/26/25. No designee for the IP listed. Review of the facility's QAPI meetings policy dated 08/01/23 revealed the facility Quality Assurance and Quality Improvement (QA/QI) Committee members include but are not limited to the DON, MD or 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 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. Further review revealed the IP was not listed as a required team member. Interview with the Administrator on 09/10/25 at 3:09 P.M. confirmed QAPI meetings dated 10/23/24, 02/10/25, 04/22/25, and 08/26/25 did not have the required members attending. The Administrator confirmed the IP was not listed as a required member in the facility's policy. Interview with Chief Operating Officer #210 on 09/10/25 at 3:17 P.M. confirmed QAPI meetings dated 10/23/24, 02/10/25, 04/22/25, and 08/26/25 did not have the required members attending. The Administrator confirmed the IP was not listed as a required member in the facility's policy.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, policy review, resident interview, and staff interview, the facility failed to maintain a clean, sanitary, and safe environment for all residents. This affected Residents #4 and #31 and had the potential to affect all 66 residents residing in the facility. Findings include: 1. Observations on 09/08/25 between 9:00 A.M. and 10:00 A.M. revealed the floors of the 200 and 300 halls contained numerous areas of dark grey and black shoe (foot) prints, dark grey and black wheelchair trail marks, and dark grey and black marks suggestive of dried liquid drips. There was dirt, grime, and dust throughout both halls. Interview on 09/08/25 at 10:02 A.M., Resident #31 described the facility cleanliness as "nasty"; and stated all of the housekeepers but one were recently fired. Interview on 09/08/25 at 11:21 A.M., Resident #4 complained the floors in the common area were not very clean and further stated he thought the floors were dirty because there was only one person in housekeeping for the entire building. Interview on 09/08/25 at 10:12 A.M., Housekeeper #109 verified the 200 and 300 halls contained numerous areas of foot prints, wheelchair marks, dried liquid, dirt, grime, and dust. Housekeeper #109 stated she was upset at the condition of the hallways when she arrived to begin her shift that morning and further stated the halls had not been cleaned over the weekend because the majority of the housekeeping staff had recently been fired. 2. Observations on 09/11/25 at 1:22 P.M. revealed a build up in the lint trap of all three dryers in the laundry room. Interview on 09/11/25 at 1:25 P.M. with Housekeeper #126 verified that the amount of lint in the trap would be from a couple loads. Housekeeper #126 stated she arrived to work at 1:00 P.M. and was doing her first load of laundry for the day. Housekeeper #126 verified the lint traps should be cleaned regularly to prevent a build up of lint. Review of the facility policy titled "Infection Control – Housekeeping", dated 10/27/21 revealed the facility procedure is to provide a safe and septic handling, washing, and storage of linens. This deficiency represents non-compliance investigated under Complaint Number 2605044, Complaint Number 2574888, Complaint Number OH00164929 (1260835), Complaint Number OH00164419 (1260832), and Complaint Number OH00166722 (1260778).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, observation, staff interview, policy review, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to follow physician orders for contact isolation precautions for Residents #57 and #13. This affected Residents #57 and #13 and had the potential to affect the residents residing on their units, 100 and 200 halls. The facility census was 66. Findings include: 1. Review of the medical record for Resident #13 revealed an admission dated of 12/14/11. Diagnoses included cerebrovascular disease, obsessive-compulsive disorder, and hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side. Review of the physician orders dated 09/09/25 revealed an order for contact isolation precautions every shift for shingles until resolved. Observation on 09/09/25 at 11:16 A.M. revealed Resident #13 sitting in the dining room, leaning on a dining room table, with ten other residents and one Certified Nursing Assistant (CNA) present. Interview on 09/09/25 11:20 A.M. with Licensed Practical Nurse (LPN) #114 confirmed Resident #13 was positive for shingles infection as of 09/09/25, Resident #13 had open and moist blisters, and should be in contact isolation. LPN #114 confirmed Resident #13 should not be in the dining room with other residents due to a diagnosis of active shingles. Interview on 09/09/25 at 11:23 A.M. with Activities Personnel #130 stated she was not aware of Resident #13 was required to be in contact isolation, and that was not communicated to her. Review of the Transmission Based Precautions policy dated 05/01/22 revealed contact precautions are required for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with the resident. If the resident is transported to another area in the facility, the facility will notify the unit of the type of precautions the resident needs. Review of CDC guidance titled Preventing FZV (Varicella-Zoster Virus) Transmission in Healthcare Settings dated 04/19/24 and found at https://www.cdc.gov/shingles/hcp/infection-control/index.html revealed facilities should use the table [Found at website] to determine if any additional infection control precautions are required. Infection control precautions are based on the patient's immune status and rash localization. 2. Record review for Resident #57 revealed an admissions date of 04/18/22 with diagnoses including cerebral infraction and dementia. Review of the physician orders dated 08/21/25 revealed Resident #57 had an order for contact isolation precautions due to wounds from the herpes simplex virus. Observation on 09/08/25 at 9:19 A.M. revealed Resident #57's room did not have a sign stating to use contact precautions prior to entering or a personal protective equipment (PPE) supply cart outside the room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/08/25 at 9:31 A.M. with Licensed Practical Nurse (LPN) #148 verified Resident #57 did not have contact isolation precaution signage or PPE stored outside the room. Interview on 09/08/25 at 9:36 A.M. with Certified Nursing Assistant (CNA) #129 verified she was recently alerted of Resident #57's contact isolation precautions order. CNA #129 stated that while she was performing care for Resident #57 that morning, the only PPE she used was gloves. Review of the facility policy titled Transmission Based Precautions dated 05/01/22, revealed when a resident has orders for contact precautions, a gown should be worn when entering the room and the facility will implement a system to alert staff to the type of precautions for the resident.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, observations, and resident and staff interviews, the facility failed to ensure all residents were provided with a safe, clean and homelike environment. This affected two (#13 and #25) of two residents reviewed for homelike environment. The facility census was 66. Findings included: 1. Observation on 09/08/25 at 8:47 A.M. revealed Resident #25's bathroom smelled of urine. There was a yellow substance surrounding the base of the toilet, and an area measuring approximately eight inches (in) by 8 in of a similarly appearing yellow substance. There were several brown marks throughout the floor of the bathroom. Interview on 09/08/25 at 8:47 A.M., Resident #25 stated his bathroom floor was dirty, and the bathroom smelled like urine. Resident #25 stated his bathroom did not get cleaned very often. Interview on 09/08/25 at 9:00 A.M., Certified Nursing Assistant (CNA) #129 verified Resident #25's bathroom had yellow stains around the base of the toilet, brown marks throughout the floor, and a strong urine odor. CNA #129 stated there hadn't been a housekeeper assigned to the 100 hall in over a month. 2. Review of the medical record of Resident #13 revealed an admission dated of 12/14/11. Diagnoses included cerebrovascular disease and obsessive-compulsive disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact and dependent on staff with ambulating. Observation on 09/08/25 at 8:54 A.M. revealed the floor tile, in Resident #13's room, had multiple pieces of tile missing. The floor tile with missing pieces was in front of Resident #13's table and was located in middle of the floor. Interview on 09/08/25 at 10:22 A.M. with Licensed Practical Nurse (LPN) #114 confirmed Resident #13's room had one floor tile in his room that has multiple pieces of tile missing. LPN #114 confirmed the floor tile was located in the walkway to the door. LPN #114 confirmed Resident #13 has two other floor tiles in his room that has one small piece missing. LPN #114 stated Resident #13 utilized a walker at times to ambulate. Review of the facilities Homelike Environment policy dated 10/27/21 revealed residents are provided with a safe, clean, comfortable and homelike environment. This deficiency represents non-compliance investigated under Complaint Number 2605044, Complaint Number 1260835, Complaint Number OH00164419 (1260832), Complaint Number OH00164929 (1260832), and Complaint Number OH00166722 (1260778).		

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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** Based on record review, staff interview, review of Self-Reported Incidents (SRI), and facility policy review, the facility failed to ensure all alleged violations of staff-to-resident physical abuse were reported timely to administration and the State Survey Agency. This affected one (#40) of five residents reviewed abuse. The facility census was 66. Findings include: Review of the medical record for Resident #40 revealed an admission date of 06/09/25. Diagnoses included cerebral infarction with left-sided hemiplegia, chronic obstructive pulmonary disease, hypertension, anxiety, and chronic respiratory failure with hypoxia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 had moderately impaired cognition. Review of the progress notes dated 07/01/25 at 6:05 A.M. revealed Licensed Practical Nurse (LPN) #160 entered Resident #40's room and heard Resident #40 yelling profanities and get off of me directed at an unknown certified nurse aide (CNA). The progress note revealed the unknown CNA was providing personal care for Resident #40. LPN #160 documented Resident #40 hit the unknown CNA twice. LPN #160 asked Resident #40 what happened, but Resident #40 would not provide an answer. According to the progress notes, approximately 20 minutes after the incident, Resident #40 apologized for her actions stating she was in her sleep. Review of the facility's SRI dated 07/01/25 to 09/10/25 revealed there were no allegations of physical abuse involving Resident #40 reported to the State Survey Agency. Interview with the Administrator on 09/09/25 at 8:49 A.M. confirmed she was not aware of the allegation of physical abuse by Resident #40 and did not report this to the State Survey Agency. Interview on 09/11/25 at 8:00 AM with LPN #160 revealed she could not remember who the CNA was during the incident that occurred on 07/01/25 but recalls that she asked the CNA to leave Resident #40's room. LPN #160 confirmed she did not report the incident on 07/01/25 to a member of administration. Review of the facility policy titled Abuse Prevention dated 08/20/21 revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, including injuries of unknown source, in accordance with this policy. Staff should report all incident/allegations immediately to the administrator or designee. This deficiency represents non-compliance investigated under Complaint Number 2574888.		

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NAME OF PROVIDER OR SUPPLIER Momentous Health at Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE 421 Mission Lane Franklin, OH 45005	
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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** Based on medical record review and staff interview, the facility failed to ensure admission comprehensive Minimum Data Set (MDS) assessments were completed within the required timeframes. This affected three (#3, #25, and #39) of three residents reviewed for resident assessment. The facility census was 66. Findings include: 1. Review of the medical record of Resident #39 revealed an admission date of 07/14/25. Diagnoses included major depressive disorder, anxiety disorder, suicidal ideations, hypertension, and morbid obesity. Review of the admission comprehensive MDS assessment dated [DATE] revealed the resident had a severe cognitive impairment. The assessment was not locked as completed until 08/18/25. Interview on 09/09/25 at 4:26 P.M., MDS Nurse #172 verified Resident #39's admission comprehensive MDS assessment was not locked as completed until 08/18/25. MDS Nurse #172 verified Resident #39's admission comprehensive MDS assessment should have been completed within 14 days of admission by 07/27/25. 2. Review of the medical record of Resident #25 revealed an admission date of 06/19/25. Diagnoses included dementia, anxiety, and depression. Review of the admission comprehensive MDS assessment dated [DATE] revealed the resident had severely impaired cognition. The assessment was not locked as completed until 07/08/25. Interview on 09/09/25 at 4:26 P.M., MDS Nurse #172 verified Resident #25's admission comprehensive MDS assessment was not locked as completed until 07/08/25. MDS Nurse #172 verified Resident #25's admission comprehensive MDS assessment should have been completed by 07/02/25. 3. Review of the medical record of Resident #3 revealed an admission date of 05/21/25. Diagnoses included cellulitis, depression, viral hepatitis C, end-stage renal disease with dependence on renal dialysis, anxiety, gastroesophageal reflux disease, and heart failure. The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of Resident #3's admission comprehensive MDS assessment dated [DATE] revealed the assessment was not completed until 06/16/25. Interview on 09/09/25 at 4:26 P.M., MDS Nurse #172 verified Resident #3's admission comprehensive MDS assessment was not completed within 14 days of Resident #3's admission. MDS LPN #172 verified Resident #3's admission comprehensive MDS assessment should have been completed by 06/15/25.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on medical record review, staff interview, and policy review, the facility failed to ensure resident care plans were complete and specific to each resident. This affected two (#3 and #55) of six residents reviewed for care planning. The facility census was 66. Findings included: 1. Review of the medical record of Resident #3 revealed an admission date of 05/21/25. Diagnoses included cellulitis, depression, type II diabetes mellitus, history of nontraumatic intracerebral hemorrhage, end-stage renal disease with dependence on renal dialysis, anxiety, gastroesophageal reflux disease, and heart failure. The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the plan of care dated 05/29/25 revealed there was no care plan to address Resident #3's ability to carry out his activities of daily living (ADLs). There was no dental care plan to address Resident #3's edentulism. Review of the quarterly MDS assessment dated [DATE] revealed the resident had moderately impaired cognition. Resident #3 was independent or required supervision for all ADLs. Resident #3 required supervision and touching assistance with walking up to 50 feet. Interview on 09/09/25 at 4:26 P.M., MDS Nurse #178 verified Resident #3's care plan was incomplete. MDS Nurse #178 verified Resident #3's care plan did not address ADLS or Resident #3's edentulism. 2. Review of the medical record for Resident #55 revealed an admission date of 06/13/24. Diagnoses included traumatic subdural hemorrhage without loss of consciousness and major depressive disorder. Review of the physician orders revealed an order dated 11/12/24 for Mirtazapine (psychotropic) oral tablet 7.5 milligrams (mg) give one tablet by mouth at bedtime related to major depressive disorder; an order dated 11/19/25 for Celexa (psychotropic) oral tablet 10 mg give one tablet by mouth at bedtime related to major depressive disorder; and an order dated 12/15/24 for Eliquis (anticoagulant) oral tablet five mg give one tablet by mouth two times a day related to acute embolism and thrombosis of deep vein of left lower extremity. Review of Resident #55's care plans revealed there were not a care plans for the medication use of anticoagulants or psychotropic medications. Interview on 09/15/25 at 8:43 A.M. with Minimum Data Set (MDS) Nurse #172 confirmed Resident #55 did not have a care plan for anticoagulants or psychotropic medications. Review of the facility policy titled Resident Care Plans dated 05/01/22 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.		

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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** Based on medical record review, staff interview, and policy review, the facility failed to ensure care plans were updated timely to reflect new diagnoses, new sexual behaviors, and medications to treat the new diagnoses and behaviors. This affected two (#45 and #57) of six residents reviewed for care planning. The facility census was 66. Findings include: 1. Record review for Resident #57 revealed an admissions date of 04/18/22 with diagnoses including cerebral infraction, dementia, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was cognitively impaired. Review of the medical laboratory records dated 08/19/25 revealed Resident #57 was positive for Herpes Simplex 1. Review of the physician's orders dated 08/24/25 revealed Resident #57 had a new order of Valtrex (treats Herpes) 500 milligrams (mg). Review of Resident #57's care plan on 09/10/25 revealed that the new diagnoses and medication was not included in the care plan. Interview on 09/10/25 at 3:40 P.M. with Director of Nursing verified Resident #57's care plan was not updated timely and it should include the new diagnosis of Herpes Simplex 1 and the new medication to treat it. 2. Record review for Resident #45 revealed an admissions date of 01/28/25 with diagnoses including alcohol dependence with alcohol induced persisting dementia. Review of the nursing progress notes revealed Resident #45 had increased sexual behaviors on 08/31/25 and 09/07/25. Review of the physician orders revealed Resident #45 was ordered medroxyprogesterone acetate five milligrams (mg) on 09/02/25 for increased sexual behaviors. Review of Resident #45's care plan revealed the care plan was not updated timely and it did not include Resident #45's sexual behaviors and the new medication to treat the behavior. Interview on 09/10/25 at 3:40 P.M. with Director of Nursing verified Resident #45's care plan was not timely updated and it should have been to include new behaviors and medications used to treat behaviors. Review of the facility policy titled Resident Care Plans dated 05/01/22 revealed assessments are ongoing and care plans are revised as information about the resident and residents' conditions change.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure residents who required assistance with activities of daily living received adequate assistance with nail care. This affected one (#22) of two residents reviewed for ADLs. The facility census was 66. Findings include: Review of the medical record for Resident #22 revealed an admission date of 01/25/24. Diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, major depressive disorder, dementia, muscle weakness, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had intact cognition. The resident was independent with personal hygiene, required setup/cleanup assistance with dressing, and required supervision or touching assistance with bathing. Review of the plan of care dated 08/06/24 revealed Resident #22 was independent/supervision for ADLs except for bathing. Interventions included to monitor for any decline and report immediately, and to setup supplies for the resident as needed. Review of task documentation dated 08/12/25 through 09/10/25 revealed Resident #22 required setup, supervision or limited assistance of one person with personal hygiene tasks and supervision and setup for bathing. Review of shower sheets dated 07/02/25 through 09/10/25 revealed Resident #22's nails were last cleaned and clipped on 08/16/25. Observation and interview on 09/08/25 at 9:51 A.M. revealed Resident #22 had several fingernails which were long, extending approximately one inch or more beyond the finger tip. Resident #22's fingernails had chipped fingernail polish and were curling and jagged around the edges. Resident #22 stated, despite her requests, staff had not assisted her with cutting her fingernails in a long time. Resident #22 stated she had carpal tunnel syndrome and was unable to cut her fingernails on her own. Resident #22 stated her fingernails were splitting and getting caught on clothing and bedding and stated she wished staff would help her cut them. Interview on 09/08/25 at 10:00 A.M., Admissions #162 verified Resident #22's fingernails were long, jagged, and curling around the edges and the resident was in need of nail care. Review of the facility policy titled Resident ADL Care, dated 07/01/23, revealed when autonomy and independence are no longer possible or feasible, facility staff will provide the necessary support in all ADL functioning. Resident nails are expected to be trimmed and kept neat to prevent skin tears, scratches, or injuries. Nail care will be provided as needed to the resident. This deficiency represents non-compliance investigated under Complaint Number 2605044, Complaint Number 2574888, Complaint Number OH00166722 (1260778), Complaint Number OH00165869 (126837), Complaint Number OH00164929 (1260835), Complaint Number OH00164419 (1260832), and Complaint Number OH00163480 (1260830).		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on record review, observation, resident and staff interviews, and policy review, the facility failed to ensure activities met the needs and preferences of the residents. This affected one (Resident #77) of two residents reviewed for activities. The facility census was 66. Findings included: Review of the medical record for Resident #77 revealed an admission date of 09/02/25 with diagnoses of paraplegia, schizophrenia, anxiety disorder, and bipolar disorder. There was no Minimum Data Set (MDS) assessment available to review due to recent admission. Interview on 09/08/25 at 12:04 P.M. with Resident #77 revealed there were no activities. Observation on 09/11/25 at 8:26 A.M. revealed the schedule of activities for September 2025 had no activities scheduled for the residents after the 2:00 P.M. everyday of the month, except for every other Tuesday when church services were scheduled at 6:00 P.M. Interview on 09/11/25 at 8:38 A.M. with Activities Director #104 confirmed there were no activities scheduled for the residents after the 2:00 P.M. scheduled activity is completed, except for every other Tuesday when church services were held at 6:00 P.M. Activities Director #104 stated there was not enough help in the activities department and she was trying to find help. Review of the activities policy dated 05/01/22 revealed activities will be scheduled periodically during the day, as well as during the evenings, weekends, and holidays.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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** Based on record review, observation, resident and staff interviews, review of U.S. Food and Drug Administration (FDA) guidance, and policy review, the facility failed to ensure residents vaped in the facility's designated smoking area. This affected one (Resident #11) of two residents reviewed for supervision. The facility census was 66. Findings include: Review of the medical record for Resident #11 revealed an admission date of 07/29/24 with diagnoses including centrilobular emphysema and Alzheimer's disease. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #11 had moderate cognitive impairment, rejected care at times and was independent with ambulation. Review of the Smoking assessment dated [DATE] revealed Resident #11 required supervision while smoking. There was no documentation that Resident #11 was non-compliant with the facility's smoking policy. Observation and interview on 09/08/25 at 10:15 A.M. revealed Resident #11 with a cloud of smoke above her knees and a vape machine in her left hand while lying in the bed. Resident #11 reported it was nothing. Licensed Practical Nurse (LPN) #114 confirmed at time of observation that Resident #11 had the vape in her room and was not allowed to have a vape in her room. The Director of Nursing (DON) went to the resident's room and spoke with the resident and removed the vape. Interview on 09/08/25 at 10:21 A.M. with Certified Nursing Assistant (CNA) #116 stated Resident #11 was always vaping in her room. Review of the facilities smoking policy dated 08/01/23 revealed the facility shall establish and maintain safe resident smoking practices, allowing residents who wish to the ability to smoke, while also doing in safe manner. Designated smoking area signs shall be prominently displayed where smoking is allowed. Smoking restrictions shall be strictly enforced in all nonsmoking areas. The facility may check periodically to determine if residents have any smoking articles in violation of their smoking policies. Review of the FDA's guidance titled E-Cigarettes, Vapes, and other Electronic Nicotine Delivery Systems (ENDS) dated 07/17/25 and found at https://www.fda.gov/tobacco-products/products-ingredients-components/e-cigarettes-vapes-and-other-electronic-nicotine-delivery-systems revealed there are no safe tobacco products, including ENDS. FDA has received reports from the public about safety problems associated with vaping products including overheating, fires, and explosions. These problems can seriously hurt the person using the ENDS product and others around them.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interviews, and policy review the facility failed to ensure the medication error rate did not exceed five percent (%). There were two observed errors out of 34 opportunities that resulted in a medication error rate of 5.88%. This affected one (Resident #42) out of four residents reviewed for medication administration. The facility census was 66. Findings include: Review of the medical record for Resident #42 revealed an admission date of 12/20/21. Review of the physician orders revealed an order dated 01/09/24 for Calcium plus Vitamin D3 Oral Tablet 500-5 milligrams (mg)- microgram (mcg) give one tablet by mouth one time a day for supplement. There was an order dated 07/17/25 for Duloxetine HCl oral capsule delayed release sprinkle 30 mg give one capsule by mouth one time a day for schizophrenia. Observations on 09/10/25 from 8:00 A.M. through 8:30 A.M. with Licensed Practical Nurse (LPN) #151 revealed LPN #155 administered 33 medications to three residents. Resident #42 was administered the following medications in error, Calcium + Vitamin D3 Oral Tablet 600-10 mg-mcg one tablet by mouth and Duloxetine HCl Oral Capsule Delayed Release Sprinkle 20 mg one capsule by mouth. Interview on 09/10/25 at 11:17 A.M. with LPN #151 confirmed she administered the wrong doses of medications to Resident #42. LPN #151 confirmed she Calcium + Vitamin D3 Oral Tablet 600-10 mg-mcg one tablet by mouth and confirmed the physician order was for Calcium + Vitamin D3 Oral Tablet 500-5 mg-mcg give one tablet by mouth. LPN #151 confirmed she administered Duloxetine HCl oral capsule delayed release sprinkle 20 mg one capsule by mouth to Resident #42 and confirmed the physician order was for Duloxetine HCl oral capsule delayed release sprinkle 30 mg give one capsule by mouth. LPN #151 stated she administered the wrong dose because that was what was available in the medication cart and she did not know what to do to get the correct dosage. Review of the medication administration policy dated 05/01/22 revealed medications will be administered as prescribed with the correct dosage. This deficiency represents non-compliance investigated under Complaint Number OH00164691 (1260834).		

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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** Based on record review, staff interview, and policy review, the facility failed to ensure medical records were complete and accurate. This affected one (#3) of 23 residents reviewed medical record accuracy. The facility census was 66. Findings include: Review of the medical record of Resident #3 revealed an admission date of 05/21/25. Diagnoses included end-stage renal disease (ESRD) with dependence on renal dialysis, and heart failure. Review of Resident #3's physician orders revealed orders dated 05/22/25 and 05/24/25 for Resident #3 to attend dialysis on Tuesday, Thursday, and Saturday with pickup at 5:30 A.M. On 05/27/25, there was an order to send Resident #3 to the emergency room for evaluation. Review of a progress note dated 05/27/25 at 7:23 A.M. revealed Registered Nurse (RN) #128 was notified Resident #3 was not picked up for transport for dialysis that morning (05/27/25) and may have missed dialysis on Saturday (05/24/25) due to transport. NP #301 was notified and an order was received to send the resident to the hospital for evaluation and treatment due to missing dialysis treatments. There was no evidence in the medical record of the physician being notified of Resident #3 missing dialysis treatments on 05/22/25 nor 05/24/25. There was no documentation the physician recommended Resident #3 going to the hospital on [DATE] and 05/24/25 and Resident #3 refusing to go to the hospital. Interview on 09/15/25 at 3:42 P.M., Physician #502 stated he was notified of Resident #3 missing dialysis treatments on 05/22/25 and 05/24/25. Physician #502 stated he suggested Resident #3 go to the hospital, however the resident refused to go to the hospital. Interview on 09/11/25 at 9:38 A.M., the Director of Nursing (DON) verified there was no documentation acknowledging Resident #3 had missed dialysis until 05/27/25. The DON verified any missed dialysis treatments and physician notification should be documented. Interview on 09/15/25 at 3:15 P.M., Chief Operating Officer (COO) #210 verified Resident #3's medical record was silent for physician notification of missing dialysis treatments on 05/22/25 and 05/24/25. Review of the facility policy titled Change in Condition Monitoring dated 05/01/22 revealed the nurse will record in the resident's medical record information relative to changes in the residents' medical condition or status.		