STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366033	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Sidney	510 Buckeye Ave Sidney, OH 45365

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, medical record review, staff and resident interview and facility policy review the facility failed to ensure shaving was completed when the resident had long hairs under her arms and on her legs. This affected one (#39) of one reviewed for dignity and respect. The census was 42. Findings included: Medical record review for Resident #39 revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, cerebrovascular accident (CVA), seizure disorder, anxiety, depression, bipolar disorder, and asthma. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact. Her functional status was set up or clean up assistance for eating, partial assistance/moderate assistance for toileting, bed mobility, and transfers. She was frequently incontinent for the bladder and always incontinent for the bowel. Review of the shower sheet for Resident #39 dated 04/07/25 revealed shaved was checked marked as no. Observation during incontinence care on 04/09/25 at 11:26 A.M. revealed the resident had long hair under her arms and on her legs and the Certified Nursing Aide (CNA) #95 acknowledged the hair was long and should have been shaved on her last shower. The resident reported to CNA #95 she did ask the CNA #106 on her last shower day if she would shave her legs and underarms, but it didn't get done. Interview with Resident #39 on 04/09/25 at 11:45 A.M. revealed on her last shower day on 04/07/25 revealed she had asked for her legs and her underarms shaved, but CNA #106 didn't do it. She stated she didn't like how long her hair was on her legs and underarms. Interview with CNA #106 on 04/10/25 at 11:27 A.M. confirmed she gave a shower to Resident #39 on 04/07/25. She revealed if she had time to shave a person she will do it, but otherwise even if she sees hair on the legs or underarms she wouldn't ask the resident even though shaving was a part of the bathing sheet. She said the resident didn't asked to be shaved. (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
	366033	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Sidney	510 Buckeye Ave Sidney, OH 45365

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy entitled Resident Activities of Daily Living Care dated 07/01/23 revealed male and female residents will be expected (per the resident's preference) to be clean shaven and assistance with shaving, when necessary, will be provided as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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** 34291 Based on medical record review, staff and resident interview, and facility policy review the facility failed to ensure reporting to the state agency was completed when an allegation of abuse was made by a resident. This affected one (#39) of one resident reviewed for reporting an allegation of abuse to the state agency. The census was 42. Findings included: Medical record review for Resident #39 revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, cerebrovascular accident (CVA), seizure disorder, anxiety, depression, bipolar disorder, and asthma. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact. Her functional status was set up or clean up assistance for eating, partial assistance/moderate assistance for toileting, bed mobility, and transfers. She was frequently incontinent for the bladder and always incontinent for the bowel. Review of the progress notes dated 04/01/25 revealed there wasn't any evidence concerning an abuse allegation. Interview with Resident #39 on 04/09/25 at 11:45 A.M. revealed she had won a meal with a lottery ticket from activities a couple of weeks ago. She reported when it came to cash in her meal ticket she got her meal and went to the dining room to eat it. She stated Licensed Practical Nurse (LPN) #49 snatched everything away from her and said you can't eat this meal in the dining room and made her go to her room to eat the meal. The resident reported this upset her tremendously and felt like this was abusive especially when the nurse snatched the meal away from her, because she thought she would be able to eat it in the dining room. She reported Certified Nursing Aide (CNA) #73 heard the interaction and told on the LPN #49. Interview with the CNA #73 on 04/09/25 at 1:31 P.M. revealed the incident with Resident #39 happened on 04/01/25 between 4:30 P.M. and 5:00 P.M. because the aide was getting ready to punch out for the day to go home. She stated Resident #39 was in the dining room with her fast food meal she received for a winning facility lottery ticket. She reported she heard LPN #49 say to Resident #39 pack it up and take this to your room, a take out meal is not to be eaten in the dining room. The aide asked the LPN since when can't the residents eat a take out meal in the dining room and the nurse didn't answer her. She reported she felt like the tone of the LPN was rude, disrespectful, and didn't understand why the resident couldn't eat in the dining room. CNA # 73 denied seeing the LPN snatch the food from Resident #39 and only heard the conversation. The aide said she went home for the day and about two to three days later she went to the Director of Nursing (DON) and asked her since when couldn't the residents eat a fast food meal in the dining room. The DON asked what happened and the aide told her about the incident that happened with Resident #39 and LPN #49. The DON told the CNA she would check into it and the resident could eat any meal in the dining room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Sidney	510 Buckeye Ave Sidney, OH 45365

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 04/09/25 at 2:20 P.M. confirmed she didn't know anything about Resident #39's allegation. She further confirmed this wasn't reported to the state agency and should have been. Review of the policy entitled Abuse Prevention dated 08/20/21 revealed facility staff should immediately report all such allegations to the Administrator and to the State Department in accordance with the procedures in this policy. a. Administrator. All incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property and all Injuries of Unknown Source must be reported Immediately to the Administrator or designee Administrator or his/her designee will notify the state of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property and Injuries of Unknown Source as soon as possible, but in no event later than twenty-four (24) hours from the time the incident/allegation was made known to the staff member. The Administrator should be notified by informing him/her in person, calling via telephone, or sending an email or text message.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, staff and resident interview, and facility policy review the facility failed to ensure an investigation into an allegation of abuse was completed. This affected one (#39) of one resident reviewed allegation of abuse. The census was 42. Findings included: Medical record review for Resident #39 revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, cerebrovascular accident (CVA), seizure disorder, anxiety, depression, bipolar disorder, and asthma. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #39 was cognitively intact. Her functional status was set up or clean up assistance for eating, partial assistance/moderate assistance for toileting, bed mobility, and transfers. She was frequently incontinent for the bladder and always incontinent for the bowel. Review of the progress notes dated 04/01/25 revealed there wasn't any evidence concerning an abuse allegation. Interview with Resident #39 on 04/09/25 at 11:45 A.M. revealed she had won a meal with a lottery ticket from activities a couple of weeks ago. She reported when it came to cash in her meal ticket she got her meal and went to the dining room to eat it. She stated Licensed Practical Nurse (LPN) #49 snatched all her food away from her and said you can't eat this meal in the dining room and made her go to her room to eat the meal. The resident reported this upset her tremendously and felt like this was abusive especially when the nurse snatched the meal away from her, because she thought she would be able to eat it in the dining room. She reported Certified Nursing Aide (CNA) #73 heard the interaction and told on the LPN #49. Interview with the CNA #73 on 04/09/25 at 1:31 P.M. revealed the incident with Resident #39 happened on 04/01/25 between 4:30 P.M. and 5:00 P.M. because the aide was getting ready to punch out for the day to go home. She stated Resident #39 was in the dining room with her fast food meal she received for a winning facility lottery ticket. She reported she heard LPN #49 say to Resident #39 pack it up and take this to your room, a take out meal is not to be eaten in the dining room. The aide asked the LPN since when can't the residents eat a take out meal in the dining room and the nurse didn't answer her. She reported she felt like the tone of the LPN was rude, disrespectful, and didn't understand why the resident couldn't eat in the dining room. She denied she could see the LPN snatch the food from Resident #39 and only heard the conversation. The aide said she went home for the day and about two to three days later she went to the Director of Nursing (DON) and asked her since when couldn't the residents eat a fast food meal in the dining room. The DON asked what happened and the aide told her about the incident that happened with Resident #39 and LPN #49. The DON told the CNA she would check into it and the resident could eat any meal in the dining room. Interview with the Administrator on 04/09/25 at 2:20 P.M. confirmed she didn't know anything about Resident #39's allegation. She further confirmed this allegation of abuse was not investigated. (continued on next page)

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Momentous Health at Sidney	510 Buckeye Ave Sidney, OH 45365

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy entitled Abuse Prevention dated 08/20/21 revealed facility staff should immediately report all such allegations to the Administrator and to the State Department in accordance with the procedures in this policy. a. Administrator. All incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property and all Injuries of Unknown Source must be reported Immediately to the Administrator or designee Administrator or his/her designee will notify the state of all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident, or Misappropriation of Resident Property and Injuries of Unknown Source as soon as possible, but in no event later than twenty-four (24) hours from the time the incident/allegation was made known to the staff member. The Administrator should be notified by informing him/her in person, calling via telephone, or sending an email or text message. Investigate: Once the Administrator and the state agency are notified, an investigation of the allegation violation will be conducted. 1. Time frame for investigation. The investigation must be completed within five (5) working days, unless there are special circumstances causing the investigation to continue beyond 5 working days (e.g., quantifying amounts misappropriated if accountant needs more time). 2. Investigation protocol. The person investigating the incident should generally take the following actions: Interview the resident, the accused, and all witnesses. Witnesses generally Include anyone who: witnessed or heard the incident; came In close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the Incident. If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift. For Injuries of Unknown Source, the investigation may generally involve talking with both the shift on duty when the injury was discovered and prior shifts as well. Obtain a statement from the resident, if possible, the accused, and each witness. Obtain all medical reports and statements from physicians and/or hospitals, if applicable. Review the resident's records. If the accused Is an employee, then review his/her employment records. 3. Documentation. Evidence of the investigation should be documented.

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Momentous Health at Sidney	510 Buckeye Ave Sidney, OH 45365

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 34291 Based on observation, staff and resident interview, medical record review and facility policy review the facility failed to ensure a resident was changed in a timely manner. This affected one (#39) of three residents reviewed for incontinence care. The census was 42. Findings included: Medical record review for Resident #39 revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, cerebrovascular accident (CVA), seizure disorder, anxiety, depression, bipolar disorder, and asthma. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact. Her functional status was set up or clean up assistance for eating, partial assistance/moderate assistance for toileting, bed mobility, and transfers. She was frequently incontinent for the bladder and always incontinent for the bowel. Review of the care plan dated 02/06/25 revealed Resident #39 was at risk for bladder incontinence. Interventions included if the resident had an incontinent episode she will need assistance to cleanse, rinse, and dry the perineum, and change clothing as needed after each incontinence episodes. Review of the bladder tracker dated 04/09/25 revealed Resident #39 was documented for check and change for bladder at 2:54 A.M. Ongoing observation of Resident #39 on 04/09/25 from 9:32 A.M. to 11:26 A.M. revealed no one entered her room to check on her. Observation of incontinence care on 04/09/25 at 11:26 A.M. revealed Resident #39 was heavily soiled with urine and her pad underneath her bottom was wet and there was an odor. Interview with the Certified Nursing Aide (CNA) #95 on 04/09/25 at 11:35 A.M. revealed at the time of the incontinence she said the resident was probably flooded. She stated she was trying to get other residents up and dressed for the day and since this resident was at the end of the hall she had not got to her yet. She confirmed the resident had not been changed since 2:54 A.M. and that she should have been changed her every two hours. The interview with the resident #39 on 04/09/25 at 11:45 A.M. revealed she would like to be changed every two hours, but it didn't happen this morning. Review of the policy entitled Resident Activities of Daily Living Care dated 07/01/23 revealed the facility believed in supporting and encouraging the autonomy and independence of all residents in activities of daily living to the fullest extent possible given the limitations of their debility and disease. Residents will be expected to maintain reasonable standards of hygiene and grooming during their stay at the facility. When autonomy and independence are no longer possible or feasible, the facility resident care staff will provide the necessary support in all ADL functioning. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistance and/or supervision will be provided as necessary with toileting. This deficiency represents non-compliance investigated under Complaint Number OH00164489.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, staff and resident interview, and policy review the facility failed to ensure fluid restriction was followed. The affected one (#33) of three residents reviewed for fluid restriction. The census was 42. Findings included: Medical record review for Resident #33 revealed an admitted [DATE]. Medical diagnosis included heart failure, hypertension and diabetes. Review of the physician orders dated 12/03/24 revealed 2,000 ml fluid restriction in a 24-hour period for congested heart failure (CHF). Dietary 1080 ml, (breakfast 480 ml, lunch 360 ml, dinner 240 ml) nursing department 920 ml in a 24-hour period (days 500 ml and nights 420 ml) to be documented every shift. Review of the care plan dated 12/03/24 revealed Resident #33 had a potential for fluid imbalance. Interventions were to provide assistance/encouragement/supervision with fluid intake to meet the daily requirements. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #33 was moderately cognitively impaired. His functional status was set up or cleanup for eating assistance, dependent on toileting, substantial/maximal assistance for bed mobility, and transfer were attempted due safety. He was always incontinent with bowel and bladder. Review of the Treatment Administration Record (TAR) from 02/01/24 through 04/09/24 revealed Resident #33 was shorted 1,000 ml fluids for 25 days and 700 ml fluids for 44 days. The interview with Resident #33 on 04/10/25 at 8:20 A.M. revealed he got thirsty and was thirsty right now and was going to ring the call light to get a cup of water. He revealed sometimes the staff will give him something to drink and sometimes they won't. Interview with CNA #85 on 04/10/25 at 9:52 A.M. revealed Resident #33 tells the staff he is thirsty and asks for water on a regular basis. She reported this was reported to the nurse and if he isn't over on his fluids the staff will get him some water to drink. Interview with Registered Dietician (RD) #110 on 04/10/25 at 10:16 A.M. revealed she took over the account for the facility on 03/17/25. She confirmed after looking at the TAR, Resident #33 was under on all days since 02/01/25. She revealed she called the nurse on duty for the resident on this day and the nurse reported the resident was thirsty and so she discontinued the order for fluid restriction so the staff could quench his thirst, and he could have what he liked to drink. Review of policy entitled Resident Nutrition Servicesdated 05/01/22 revealed nursing personnel will evaluate (and document as indicated) fluid intake of resident with, or at risk for, significant nutritional problems. Variations from intake patterns will be recorded in the resident's medical record and brought to the attention of the nurse. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00164489.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34291 Based on observation, staff interview and facility policy review, the facility failed to ensure handwashing or sanitizing was completed between dirty to clean surfaces. This affected six (#39, #5, #23, #41, #28 and #37) out of six residents reviewed for handwashing. The census was 42. Findings included: Observations made on 04/10/25 at 7:42 A.M. during a meal service revealed Activities Director (AD) #63 delivered a breakfast tray to Resident #39 and came out of the room opened the cart and got another tray and went into Resident #5's room and opened the lids for the meal. She went out of the room and got another tray off of the cart and delivered it to Resident # 23's room, left that room and went down the hall to the kitchen to grab a milk for Resident #23. AD #63 proceeded to leave the 100 hall and went down to the 200 hall and proceeded to pass trays to Resident #41 and left the room and went to the cart and got a tray and delivered it to Resident #41 and left the room and went back to the dietary cart and got a tray for Resident #28 and entered the room and touched the resident on the shoulder twice and and opened the bowls for the resident and used her bare hands to butter and jelly the toast. AD #63 left this room and went down the hall and got some milk for Resident #41 and touched the resident again. She left this room, went to the dietary cart and grabbed a tray and delivered it to Resident #37. Interview with AD #63 on 04/10/25 at 8:00 A.M. confirmed she should have washed her hands or sanitized them in between at least every two residents and should have used gloves if she was going to touch the toast for Resident #28. Interview with Certified Nursing Assistant (CNA) #73 on 04/10/25 at 8:01 A.M. revealed the staff should be washing their hands or sanitizing in between each resident and should wear gloves if they touch the food. Interview with Director of Operations (DO) #112 and Administrator on 04/10/25 at 9:29 A.M. revealed handwashing should be done by the staff if the staff member is touching articles in the room or the food. Review of the policy entitled Hand Hygiene dated 02/19/25 revealed effective hand hygiene reduces the incidence of healthcare-associated infections. All members of the healthcare team will comply with current Centers for Disease Control (CDC) hand hygiene guidelines. Handwashing and sanitizing may also be used for routinely decontaminating hands in the follow situations: before having direct contact with residents. This deficiency represents non-compliance investigated under Complaint Number OH00164489.