STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366035	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentous Health at Vandalia	208 North Cassel Road Vandalia, OH 45377

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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. Based on review of the medical record, observation, resident interview, staff interview, and review of the facility policy, the facility failed to maintain resident rooms in good repair. This affected two (Residents #69 and #80) of 32 residents reviewed The facility census was 108 residents.Findings include: 1.Review of the medical record for Resident #80 revealed an admission date on 12/11/25 with diagnoses including paranoid schizophrenia, presbyopia, and diabetes mellitus two. Review of the Minimum Data Set (MDS) assessment for Resident #80 dated 12/26/25 revealed resident had moderate cognitive impairment. Observation on 03/09/26/26 at 5:02 P.M. of Resident #80's room revealed there were multiple small holes on the bedroom wall and the outside of the bathroom door had scratches and chipped paint. Interview on 03/09/26 at 5:02 P.M. with Resident #80 confirmed she did not like the holes on the bedroom wall and she felt the bathroom door with the scratches and chipped paint should be repaired. Interview on 03/16/26/26 at 9:18 A.M. with Maintenance Assistant (MA) #313 confirmed there were multiple small holes in Resident #80's wall made by screws which should have been filled in with plaster and repaired. MA #313 confirmed Resident #80's bathroom door was scratched and needed to be repainted. 2. Review of the medical record for Resident #69 revealed an admission date of 03/04/26 with diagnoses including, cerebral infarction, major depressive disorder, and diabetes mellitus. Review of the MDS assessment for Resident #69 dated 02/26/26 revealed resident was cognitively intact. Observation on 3/09/26 at 9:14 A.M. of Resident #69's room revealed the bedroom door was difficult to shut as the door was cracked and got caught on the door frame. Interview on 03/09/26 at 10:13 A.M. with Resident #69 confirmed she was concerned about her bedroom door being in poor repair and that the door was unable to be fully closed. Interview on 3/16/26 at 9:14 A.M. with MA #313 confirmed Resident #69's bedroom door needed the hinges adjusted so it would not catch on the door frame and there were cracks on the side of the door. Review of facility policy titled Homelike Environment dated 05/01/22 revealed that facility would provide a homelike and orderly environment for the residents.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 medical record review, staff interview, and review of the facility policies the facility failed to implement interventions and provide sufficient supervision to prevent residents from ingesting foreign objects. This affected one (Resident #8) of three residents reviewed for supervision. The facility also failed to ensure fall prevention interventions were in place. This affected one (Resident #7) of three residents reviewed for supervision. The facility also failed to ensure hazardous chemicals were secured. This had the potential to affect the following facility-identified cognitively impaired and independently mobile (Residents (#27, #44, #55, #59, and #80) on the 100 hall. The facility census was 108 residents. Findings include:1.Review of the medical record for Resident #8 revealed an admission date of 11/22/25 with diagnoses including pica, borderline personality disorder, bipolar, morbid obesity, and conversion disorder. Review of a nurse progress note for Resident #8 dated 12/17/25 at 7:04 A.M. revealed while nurse was on the phone the resident put a thumb tack in her mouth. Another nurse tried to get Resident #8 to spit the thumb tack out, but the resident swallowed it. Staff called emergency medical services (EMS) and transported the resident to the hospital. Review of the hospital note for Resident #8 dated 12/17/25 revealed the resident presented to emergency department after swallowing a thumb tack. Resident #8 passed the thumb tack through her digestive tract spontaneously and sustained no injuries. Review of the nurse progress note for Resident #8 dated 01/10/26 revealed the resident told staff she had gotten a battery from a blood pressure cuff at the nurses' station and swallowed it and then called 911. Resident #8 said she had gotten into an argument with her mom, and she swallowed the batter because she was mad. EMS transported Resident #8 to the hospital. Review of the hospital note for Resident #8 dated 01/10/26 revealed the resident was admitted to the hospital for ingestion of two triple A sized batteries. Resident #8 passed the batteries through her digestive tract spontaneously and sustained no injuries. Review of a nurse progress note for Resident #8 dated 01/31/26 revealed the resident told the nurse she ate the battery out of the thermostat. Th nurse called EMS and the resident was transported to the hospital. Review of the hospital note for Resident #8 dated 01/31/26 revealed the resident was admitted to the hospital following ingestion of two double A batteries. The hospital staff successfully removed the batteries from Resident's stomach using a Roth net (a device used to retrieve items from the digestive tract), and the resident sustained no injuries. Review of the care plan for Resident #8 dated 02/03/26 revealed the resident had a behavior problem which included swallowing batteries and other foreign objects. Interview on 03/11/26 at 11:24 A.M. with Licensed Practical Nurse (LPN) #331 confirmed Resident #8 had a behavior of swallowing batteries and/or other foreign objects after she had an argument with her parents or she was told that she couldn't have or do something she wanted to do. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/12/26 1:30 P.M. with the Chief Operating Officer (COO) confirmed Resident #8 was admitted to the facility from a sister facility and had exhibited the behavior of swallowing foreign objects in the sister facility. The COO confirmed they transferred Resident #8 to the facility because she would be able to be in a smaller secured unit where they could provide a higher level of supervision. The COO stated the facility knew upon admission that Resident #8 had the behavior problem of ingesting foreign objects, but the facility did not put a care plan in place regarding the behavior until 02/03/26. The COO confirmed Resident #8 had three incidents of ingesting foreign objects followed by transport to the hospital on [DATE], 01/10/26, and 01/31/26. Interview on 03/19/26 at 2:00 P.M. with the Administrator and the Director of Nursing (DON) confirmed the facility had not completed follow-up investigations to determine root cause and interventions to prevent recurrence for the incidents for Resident #8 on 12/17/25, 01/10/26, and 01/31/26 Review of the facility policy titled Safety and Supervision of Residents dated 05/01/22 revealed the facility tried to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The care team should implement targeted interventions to reduce individual risks to hazards in the environment, including adequate supervision (such as 15-minute checks or closer observation) and assistive devices. Other interventions could include specific activities for the residents or taking them for a walk outside the facility. Review of the facility policy titled Falls and Incident Investigations dated 07/22/22 confirmed would investigate all resident occurrences whether falls or incidents to ascertain root cause and have a plan developed to prevent reccurrence. 2. Review of the medical record for Resident #7 revealed an admission date of 01/05/21 with diagnoses including alcohol abuse, anxiety disorder, and major depressive disorder. Review of the physician's orders for Resident #7 revealed an order dated 04/28/25 for Dycem (a rubberized mat to prevent slipping) to wheelchair every shift. Review of the MDS assessment for Resident #7 dated 12/19/25 revealed the resident had impaired cognition and required staff assistance with activities of daily living (ADLs.) Review of the fall care plan for Resident #7 dated 01/13/26 revealed the resident was at risk for falls related to impaired cognition, impaired mobility, resistance to care, and use of psychotropic drugs. Interventions included the following: bed against wall for environmental enhancement, bed in lowest position at all times unless providing care, bring resident to the common area when restless, Dycem above and below wheelchair cushion, Dycem to wheelchair seat, encourage to remind to ask for assistance, floor mat next to the bed when the resident was in bed. Observation on 03/11/26 at 1:45 P.M. of Resident #7 revealed the resident was lying in bed with no fall mats beside the bed. Next to the bed was Resident #7's wheelchair with no Dycem above or below the wheelchair cushion. Interview on 03/11/26 at 1:45 P.M. with Certified Nurse Aide (CNA) #240 confirmed Resident #7 was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	lying in bed and did not have a fall mat beside the bed. CNA #240 confirmed the wheelchair parked next to Resident #7 belonged to the resident and did not have Dycem above or below the wheelchair cushion. Interview on 03/11/26 at 1:50 P.M. with Registered Nurse (RN) #327 confirmed Resident #7's care plan indicated the resident was supposed to have fall mats beside the bed when the resident was in bed and was supposed to have Dycem to his wheelchair above and below the wheelchair cushion. Observation on 03/16/26 at 8:25 A.M. of Resident #7 revealed the resident did not have Dycem to his wheelchair above or below the cushion. Interview on 03/26/26 at 8:25 A.M. with the DON confirmed Resident #7 did not have dycem to his wheelchair above or below his wheelchair cushion. Review of the facility policy titled Falls and Incident Investigations dated 07/22/22 confirmed the facility would implement fall prevention interventions to prevent resident falls. 3. Observation on 03/09/26 at 10:53 A.M. on the 100 hall revealed there janitor's closet was unlocked and contained three containers of sanitizing chemicals labeled as Concentrated Sanitizing Fabric Refresher. The containers had warning labels indicating they should be kept of reach of children, and they could be hazardous to humans and domestic animals. The substance in the containers was corrosive and could cause irreversible eye damage and could be harmful if absorbed through skin. Interview on 3/9/26 at 10:53 A.M. with CNA #274 confirmed the janitor closet on the100 hall was not locked and contained three containers of sanitizing chemicals with warning labels. Interview on 3/9/26 at 11:00 A.M. with LPN #248 confirmed janitor closet on the 100 hall should be locked when unattended. Observation on 3/11/26 at 12:02 P.M. revealed the janitor closet on the 100 was unlocked and there were three containers of sanitizing chemicals inside. Interview on 3/11/26 at 12:02 P.M. with Registered Nurse (RN #228) confirmed the janitor closet was unlocked and there were three containers of sanitizing chemicals inside. Interview on 3/11/26 at 3:57 P.M. with Administrator confirmed the janitor closet as unlocked and there were three containers of sanitizing chemicals. Administrator confirmed the janitor closet should be locked and this was of particular concern for the following facility-identified residents who were cognitively impaired and independently mobile: Residents #27, #44, #55, #59, and #80. This deficiency represents noncompliance investigated under Complaint Number 2703709.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on medical record review, resident interview, and staff interview, the facility staff failed to provide pain management interventions as ordered by the physician and per resident request. This affected one (Resident #42) of six residents reviewed for pain management. The facility census was 108 residents. Findings include: Review of the medical record for Resident #42 revealed an admission date of 12/03/25 with diagnoses including osteoarthritis, obstructive sleep apnea, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 01/07/26 revealed the resident was cognitively intact. Review of the physician's orders for Resident #42 revealed an order dated 01/19/26 for Voltaren gel to be applied to the resident's right shoulder topically every six hours as needed for pain. Review of the Medication Administration Record (MAR) for Resident #42 dated March 2026 revealed there was no record of administration of Voltaren gel on 03/07/26, 03/08/26, 03/09/26, and 03/10/26. Interview on 03/09/26 at 1:12 P.M. with Resident #42 confirmed he requested his as needed Voltaren gel on 03/07/26 and 03/08/26, but the nurses told him it was not available. Interview on 03/11/26 at 11:09 A.M. with Resident #42 confirmed he requested his as needed Voltaren gel on 03/09/26 and 03/10/26, but the nurses told him it was not available. Interview on 03/11/26 at 11:59 A.M. with Licensed Practical Nurse (LPN) #231 confirmed Resident #42 had a physician's order for Voltaren gel and had asked for the medication to be applied to his right shoulder, but the medication was out of stock. This deficiency represents noncompliance investigated under Complaint Number 1360651.