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	06/08/2026

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record review, staff interviews and policy review, the facility failed to the resident had safe, clean, comfortable and homelike environment. This affected seven Residents (#36 ,#60, #45, #46, #90, #91, and #95) out of seven residents reviewed for environment. The facility census was 107.Findings include 1) Review of the medical record for Resident #36 revealed an admission date of 05/01/26. Diagnoses included bipolar disorder, anxiety disorder, and schizoaffective disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was independent with transfers and mobility. Observation of Resident #36's room on 06/03/26 at 12:17 P.M. revealed a very pervasive urine odor. During an interview on 06/03/26 at 12:18 P.M., Resident #36 stated her roommate (Resident #37) smelled of urine and refused to be changed. Resident #36 voiced her concerns related to the constant smell of urine in her room. During an interview on 06/03/26 at 12:19 P.M. Certified Nursing Assistant (CNA) #67 verified Resident #36's room had a strong smell of urine. CNA #37 reported Resident #37 was noncompliant with care and refused to let staff change her after she's soiled. 2) Review of the medical record for Resident #60 revealed an admission date of 02/01/24. Diagnoses included obsessive compulsive disorder (OCD), schizoaffective disorder, bipolar type, and dementia. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #60 had intact cognition as evidenced by a BIMS score of 15. This resident was independent with transfers and mobility. Observation of Resident #60's room on 06/03/26 at 12:22 P.M. revealed a strong pervasive odor or urine. During an interview at the same time, Resident #60 complained of the room smelling of urine because of the roommate (Resident #59). During an interview on 06/03/26 at 12:25 P.M., Licensed Practical Nurse (LPN) #23 verified Resident #59 and Resident #60's room had a strong odor of urine. LPN #23 reported Resident #59 was noncompliant with care. 3) Review of the medical record for Resident #45 revealed an admission date of 11/01/22. Diagnoses (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included chronic obstructive pulmonary disease (COPD), OCD, and type II diabetes mellitus (DM II). Review of the Quarterly MDS assessment dated [DATE] revealed Resident #45 had severely cognitive impairment as evidenced by a BIMS score of zero. This resident was independent with transfers and mobility. Review of the progress note for Resident #45 dated 04/07/26 at 10:20 A.M., revealed Nurse Practitioner (NP) #200 ordered an x-ray to the residents right shoulder due to status post fall and discoloration. The Guardian was notified. Review of the progress note for Resident #45 dated 04/07/26 at 4:21 P.M. revealed the resident was assessed by Registered Nurse (RN) #59 and noted to have swelling to the resident's right shoulder and clavicle area and the area was light pink in color. Resident #45 was observed hitting and pushing her room door open with her right shoulder. New order for x-ray given. The Guardian was made aware. Review of the witness statement dated 04/07/26 by CNA #81, revealed Resident #45 was hitting her right shoulder on the door to open her room door. Review of the witness statement dated 04/07/26 by CNA #55, revealed Resident #45 had to use her right shoulder to push her room door open. Review of the x-ray results dated 04/08/26 at 3:35 A.M., revealed Resident #45 had a comminuted fracture (a type of broken bone where the bone is shattered, splintered, or crushed into three or more pieces) of the distal third of the right clavicle. Review of the progress note for Resident #45's dated 04/09/26 at 2:16 P.M., revealed after an investigation was completed, RN #59 was alerted to the resident's right shoulder and clavicle swelling. NP #200 was notified and ordered an x-ray. Resident #45 injured her right shoulder when she used her right shoulder to hit her room door to get it to open . Review of the work order dated 05/19/26, revealed Resident #45's door was significantly sticking, and Resident #45 had a difficult time getting into her room. During an interview on 06/03/26 at 9:36 A.M., CNA #81 stated Resident #45's door was hard to push open, and the resident had to use her right shoulder to push the door open by ramming her right shoulder into the door. During an interview on 06/03/26 at 10:26 A.M., CNA #55 stated Resident #45 had a cherry red discoloration to the top of her right shoulder on 04/07/26, and by the end of the shift, it was swollen and turning purple. CNA #55 reported Resident #45 would use her right shoulder to hit her room door to open it. During an interview on 06/03/26 at 11:05 A.M., NP #200 stated she was rounding in the building on 04/07/26 and noticed Resident #45's right shoulder was swollen. NP #200 stated she assessed the resident and she had a purple hematoma and tenderness with palpation, so she ordered an x-ray. During an interview on 06/03/26 at 12:15 P.M., RN #59 stated Resident #45's shoulder was red and edematous on 04/07/26. RN #59 stated the resident's door sticks, and she put in a work order on 04/07/26 for maintenance to fix it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #59's room door on 06/03/26 at 2:00 P.M., revealed the room was very difficult to open. The surveyor had to push hard on the door to get it to open. The door was dragging the ground causing it to stick on the floor. The bottom two doors hinges were loose allowing them to move when the door was opened and closed. Observation of Resident #59 attempting to enter her room on 06/03/26 at 2:03 P.M. with LPN #112, revealed the resident had to use her right shoulder by hitting her shoulder on the door to get it open. Interview with LPN #112 at the same time, verified the findings. 4) Review of the medical record for Resident #95 revealed she was admitted to the facility on [DATE]. Her diagnoses included angina pectoris, diabetes mellitus, anemia, encephalopathy, major depressive disorder, and adult failure to thrive. The resident was assessed to be cognitively intact and independently ambulatory in a wheelchair. Observation of Resident #95's room on 06/03/26 at11:45 A.M., revealed was seated in a wheelchair in the hallway and CNA #76 was standing next to the resident. Resident #95 #95's door handle was broken with a large notch missing out of the wooden door holding the handle in place. Observation at the same time revealed the resident's bathroom door was sticking and it was very hard to open. During an Interview on 06/03/26 at 11:45 A.M., Resident #95 stated she was frustrated that her room door handle and door was broken. Resident #95 stated her room door does not close properly due to the handle being broken. Resident #95 stated she was also frustrated because her bathroom door was sticking and not functioning properly. Resident #95 revealed the facility was aware of the issues; however, nothing wsa being done to fix the issues. During an interview on 06/03/26 at 11:47 A.M., CNA #76 confirmed the conditions of Resident #95's room and bathroom doors. 5) Review of the medical record for Resident #90 revealed she was admitted to the facility on [DATE]. Her diagnoses included paranoid schizophrenia, diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), chronic viral hepatitis, and hyperlipidemia. The resident was assessed to be cognitively intact and independently mobile. Medical record review for Resident #91 revealed she was admitted to the facility on [DATE]. Her diagnoses included dementia, anxiety, vascular dementia, osteoarthritis, hyperlipidemia, and hypothyroidism. The resident was assessed to be cognitively intact and independently mobile. Observation of Residents #90 and #91's room door on 06/03/26 at 11:47 A.M., with CNA #76, revealed the room door was not functioning properly and hard to open. Interview with CNA #76 at the same time, verified the condition of Residents #90 and #91's door. During an interview on 06/03/26 at 1:50 P.M. the Administrator stated Residents #90, #91,#94,and #95's room doors were part of the facility's plan of correction from the annual survey in March 2026. The Administrator provided a signed note dated 04/17/26 from the maintenance departments stating they audited and repaired all the resident's doors. The Administrator verified the signed document did not indicated what room doors were fixed or how many doors were repaired. Observation at the same time revealed the Administrator provided an untitled, handwritten document dated 04/17/26 and signed by Maintenance Supervisor (MS) #01 indicating all resident room doors were assessed and all necessary repairs were completed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) Review of the medical record for Resident #46 revealed she was admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder, bipolar disorder, osteoarthritis, obesity, anxiety disorder, and chronic obstructive pulmonary disease (COPD). Observation of Resident #46's window on 06/01/26 at 11:13 A.M. with the Administrator revealed the window was broken and a large piece of wood covered the window. During an interview on 06/01/26 at 11:14 A.M., the Administrator confirmed the window was broken with a large piece of wood covering Resident #46's window. During an interview on 06/03/36 at 2:40 P.M., Resident #46 stated she moved in approximately six weeks ago and the window was broken and covered with wood when she moved in. Review of the facility policy titled, Homelike Environment, dated 05/01/22, revealed the residents are to be provided with a safe, clean, comfortable environment. The facility shall provide a clean, comfortable, and sanitary environment. This deficiency represents non-compliance investigated under Complaint Number 3009546.

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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 observation, staff interview, resident interview, medical record review, 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 #33) of three (#31, #33, #42) residents reviewed for accident hazards. The facility also failed to ensure a clean and safe smoking area for the residents on the men's and women's secured unit. This had the potential to affect 19 Residents (#29, #30, #31, #32, #33, #35, # 39, #42, #50, #51, #52, #55, #61, #62, #63, #64, #65, #66, and #68) who the facility identified as smokers and utilized the outdoor smoking area. The facility also failed to ensure the secured unit was properly secured. The facility identified 41 Residents (#28, #29, #30,# 31, #32, #33, #34, #35, #36, #37, #38, #39, #40. #41,#42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68) who resided on the secured unit and was independently mobile. The facility census was 107.Findings include: 1) Review of the medical record for Resident #33 revealed an admission date of 11/22/25 with diagnoses including suicidal ideation, obstructive, bipolar disorder, borderline personality, asthma, pica, paroxysmal atrial fibrillation, depression, intellectual disabilities (ID), conversion disorder, and morbid obesity Review of the care plan for Resident #33 dated 02/03/26 revealed the resident had a behavior problem which included swallowing batteries and other foreign objects.Review of the facility incident/accident log from 04/01/26 through 05/31/26, revealed the facility did not record the incidents involving Resident #33 on 04/05/26, 05/14/26, 05/23/26 and 05/26/26. Review of the nurse's progress note for Resident #33 dated 04/05/26 at 2:59 P.M. and authored by Licensed Practical Nurse (LPN) #17, revealed Resident #33 called the police and told them she ate a battery. Resident #33 was observed walking out of her room with a thermometer in her hand. Resident #33 stated she ate the battery from the thermometer the nurse left out on the table. Resident #33 was transferred to the hospital. (incident 1) Review of the nurse's progress note for Resident #33 dated 04/05/26 at 11:48 P.M. and authored by LPN #17, revealed Resident #33 had surgery and two batteries were removed. Review of the nurse's progress note for Resident #33 dated 04/08/26 at 2:43 P.M. and authored by LPN #17, revealed the resident returned to the facility following a hospital stay. Review of the nurse's progress notes for Resident #33 dated 05/14/26 at 12:16 P.M. and authored by LPN #07, revealed the resident reported that she swallowed two small batteries. Resident #33 stated she took them from the pulse oximetry machine and then later stated she got them from the night shift. Resident was monitored. Review of the nurse's progress notes for Resident #33 dated 05/14/26 at 1:34 P.M. and authored by the Unit Mnager (UM) #07, revealed the resident stated she swallowed batteries from the pulse oximetry machine. The resident was sent to the hospital for evaluation.Review of the hospital notes for Resident #33 dated 05/14/26, revealed Resident #33 swallowed a foreign body.Review of Minimum Data Set (MDS) for Resident #33, dated 05/14/26, revealed Resident #33 had impaired cognition. Resident #33 was independently mobile. Review of the nurse's progress notes for Resident #33 dated 05/17/26 at 2:50 P.M. and authored by Registered Nurse (RN) #59, revealed Resident #33 readmitted to the facility from the hospital. Review of the nurse's progress notes for Resident #33 dated 05/23/26 at 11:14 P.M. and authored by LPN #45 revealed Resident #33 approached the nurse's station and stated she swallowed a screw. The resident pointed toward the shower room area when questioned where she got a screw. The resident was sent to the emergency room for evaluation. Review of the hospital paperwork for Resident #33 dated 05/23/26 revealed the resident swallowed a foreign body.Review of the nurse's progress notes for Resident #33 date 05/24/26 at 6:29 A.M. and authored by LPN #45, revealed Resident #33 returned to the facility from the hospital. Resident #33 underwent endoscopic removal of a screw the resident swallowed. Review of a nurse's progress note dated 05/26/26 at 6:54 A.M. and authored by LPN #96, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #33 reported that she swallowed a battery. Resident #33 stated it was a flat round battery from the television remote. Resident was sent out to the hospital.Review of the hospital note for Resident #33 dated 05/26/26, revealed the resident was admitted to the hospital related to swallowing a foreign object. The resident had invasive procedures to remove the foreign objects and was discharged back to the facility on [DATE] with instructions to remove all small objects from the Residents room for safety. Review of the nurse's progress note for Resident #33 dated 05/30/26 at 7:06 A.M., authored by LPN #45 revealed Resident #33 returned from the hospital with discharge instructions to remove small object's from Resident #33's room for safety. During an interview won 06/03/26 at 1:42 P.M., the Director of Nursing (DON) stated Resident #33 was quick to grab items from the nurse's desk. The DON stated she thought about placing some type of dividers up around the nurse's station but never did. The DON verified the above incidents involving Resident #33 on 04/05/26, 05/14/36, 05/23/26 and 05/26/26. The DON revealed the guardian had ask the facility to sweep Resident #33's room to ensure Resident #33 was safe to return to her room. The DON confirmed the facility failed to update Resident #33's care plan with any new interventions regarding swallowing foreign objects since February 2026. The DON verified the incidents on 04/05/26, 05/14/26, 05/23/26 and 05/26/26 involving Resident 33 swallowing foreign object were not recorded on the accident /incident log.Review of the facility policy titled Safety and Supervision of Residents dated 05/01/22 revealed the facility would 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 recurrence. 2) Observation of the secured unit on 06/01/26 at 10:05 A.M. with LPN #122, revealed the exterior door leading to the unsecured courtyard was unlocked and not alarmed and would freely allow a resident to walk out the door without staff's knowledge. The surveyor was able to open the freely door with no alarm sounding. There were several residents moving throughout the secured unit and no staff were present at the door Directly outside the exterior door was a large broken concrete pad with numerous large chunks of broken cement lying all around the concrete pad and throughout the courtyard. There was a large stack of bricks lying on the ground next to the building. The red metal can that held cigarette butts and ashes was full of cigarette butts. There were hundreds of cigarettes butts strewn all around the cement pad, in the courtyard, in the flower beds with mulch and directly next to the building. There was a large piece of wood covering a broken window to Resident #46's room which was in the same area were residents smoke and numerous cigarette butts were around the boarded-up window. There was no fire blanket and no fire extinguisher near the smoking area. The gate door that exited the secured courtyard was hanging open due to a broken lock assembly and the keypad was broken. The Surveyor was able to exit directly from the courtyard to an open field next. There were no staff present in the courtyard during numerous observations. During an interview on 06/01/26 at 10:10 A.M., LPN #122 confirmed the door to the smoking area for the secured unit was unlocked, unalarmed and unsupervised by staff. LPN #122 stated exterior door had an alarm, but it was not functioning. LPN #122 confirmed the concrete pad was broken and had large chunks of missing concrete. LPN #122 verified the missing chunks of concrete were strewn about the concrete pad and in the courtyard. LPN #122 verified the red metal can was full of cigarette butts and ashes. LPN #122 verified there were hundreds of cigarette butts strewn all around the area. LPN #122 stated the large piece of wood was covering a broken window and verified there were cigarette butts around the piece of wood covering the window to Resident #46's room. LPN #122 confirmed there was no smoking blanket or fire extinguisher in the area. LPN #122 verified the large stack of red bricks piled (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up directly next to the concrete pad. LPN #122 verified the area was not secured and the gate leaving the secured courtyard was hanging open and the keypad was not working. Observation of the secured unit on 06/01/26 from 10:10 A.M. -10:40 A.M. with LPN #122 revealed the door across the hall from the activity room on the women's section of the secured unit opened directly to the unsecured courtyard and failed to alarm when opened. There was a sign on the door indicting the door had a fifteen second egress when pushed. Continued observation of the door located inside the men's section of the secured unit leading directly outside to an unsecured area did not alarm when opened. There was a sign on the door that indicated the door had a fifteen second egress when pushed. Observation of the door at the end of the three hundred hallway on the men's section of the secured unit revealed it would not open nor alarm when the bar was pushed. Observation of LPN #122 trying several times to open the door without success. LPN #122 was observed pushing on the door very hard several times before it finally opened. When the door opened, there was no audible alarm. There was a sign on the door that indicated the door would alarm after a 15 second egress. During an interview on 06/01/26 at 10:40 A.M. , LPN #122 on 06/01/26 at 10:40 A.M. verified the findings in the secured unit concerning the doors. Observation of the women's section of the secured unit on 06/01/26 at 11:13 A.M., with the Administrator, revealed the exterior door leading to the unsecured courtyard was unlocked, not alarmed and unsupervised. The Administrator stated the red bucket was full of cigarette butts and ashes was full because no on uses that for an ashtray. The Administrator stated the large pile of bricks was likely from some construction at the building. The Administrator verified the courtyard was unsecured due to the gate and alarm at the gate being broken. During an interview on 06/01/26 at 12:07 P.M., Maintenance Supervisor (MS) #01 revealed he was aware of the unsecured door leading the unsecured courtyard. MS #01 stated he made the Administrator aware of the smoking area needing a fire blanket and fire extinguisher over a week ago. Subsequent observations in the secured unit on 06/03/26 at 2:36 P.M. with LPN #112, revealed the large sliding window next to the exterior door was able to be opened all the way and without any restrictive devices attached to the window. During an interview with LPN #112 at the same time, verified the large window was able to be opened all the way without any restrictive devices on the window and led to the unsecured courtyard. Review of the facility policy titled, Smoking, dated 05/01/22, confirmed the facility shall establish and maintain safe resident smoking practices, and Residents will smoke in a safe manner.This deficiency represents non-compliance investigated under Complaint Number 2974781.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility failed to ensure residents who had bed rails affixed to their beds were properly assessed and monitored for safety. This affected one (#42) out of three Residents (#31,#40, and #42) reviewed for bedrails. The facility identified a total of eleven Residents (#29, #30, #31, #34, #35, #38, #40, #41, #42, #46, and #48) who required assist bars on the secure unit. The facility census was 107.Findings include: Medical record review for Resident #42 revealed she was admitted to the facility on [DATE]. Diagnoses included conversion disorder with seizures, bipolar disorder, adult failure to thrive, major depressive disorder, hyperlipidemia, hypoglycemia, autistic disorder, cerebral aneurysm, aphasia, joint derangement. The Resident required hospice services. Review of the active care plan for Activity of Daily Living (ADL) assistance and falls for Resident #42 revealed intervention for bilateral assist bars to Resident #42 ?s to bed to assist and enhance with bed mobility. There was an active care plan in place related to wound care and interventions including padding and protecting the foot board of Resident #42's bed. There were no interventions related to padding the half side rails on Resident #42's bedReview of the most recent side rail assessment for Resident #42 dated 08/11/22, revealed the resident was marked as not having side rails.Review of the Enabler Evaluation/Assessment for Resident #42 dated 01/06/26, revealed the secured unit was listed as the device assessed and there was no other information related to the resident having side rails on the assessment. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #42 was cognitively impaired. Resident #42 was dependent on staff for all ADL. The assessment indicated there were no bed rails utilized. Review of a progress note for Resident #42 dated 05/25/26 at 7:47 P.M. and authored by Licensed Practical Nurse (LPN) #112, revealed the resident was noted to have a bruise to the right side of her forehead. The resident moved around in her bed. Review of a progress note for Resident #42 dated 05/26/26 at 3:35 P.M. and authored by the Director of Nursing (DON), revealed an interdisciplinary team (IDT) investigated Resident #42 having bruising to her forehead. Resident #42 was assessed and the area appeared to be consistent with Resident #42 hitting her forehead on her side rails. The new intervention was for the siderails to be padded and protected.Review of the Skin Assessment for Resident #42 dated 05/25/26 at 7:31 P.M., revealed a bruise located on the top of her scalp that measured 10 centimeters (cm) by 7 cm. The report revealed old bruising noted to the right side of Resident #42's forehead.Review of the incident report dated 05/25/26 at 3:00 P.M., and authored by LPN #112, revealed Resident #42 had old bruising noted to her forehead and had a bruise of unknown origin. LPN #112 noted Resident #42 flails around in her bed. The physician and family were notified. Review of a staff statement dated 05/25/26 and authored by Certified Nursing Assistant (CNA) #06 revealed when care was being provided to Resident #42, she would flail around and hit her head on the side rails. Review of a staff statement dated 05/25/26 and authored by CNA #67 revealed Resident#42 would flail around in the bed when care was being provided and Resident #42 would hit her head on the side rails.Observation of Resident #42 on 06/03/26 at 11:58 A.M. with LPN #112, revealed the resident was in her bed with head facing the footboard with half bed rail on each side the upper part of the bed. There was kerlix wound dressing partially and a thin layer wrapped on the side rails. During an interview at the same time with LPN #112, verified Resident #42 was in bed with half bed rails on each side of her bed with kerlix wrapped on the bed rails. LPN #112 stated Resident #42 was unable to assist with bed mobility, and the bed rails were because Resident #42 moved around in her bed.Subsequent observation of Resident #42 on 06/03/26 at 2:35 P.M. with LPN #112, revealed the resident was lying with her head towards the footboard and there were two half bed side rails in the up position. The half size bed rails were wrapped with a thin layer of discolored Kerlix wound (continued on next page)

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	06/08/2026

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressings. Resident #42 was observed with bruising on her forehead over her right eye and forehead.During an interview on 06/03/26 at 2:36 P.M., LPN #112 confirmed Resident #42 was lying in bed upside down with the half size bed rails up and covered with a thin layer of discolored Kerlix wound dressing. LPN #112 stated Resident # 42 moved around in her bed which resulted in a bruising to her forehead. LPN #112 stated the bed rails on Resident #42's bed were half rails. LPN #112 stated the hospice company was supposed to supply something for Resident #42's bed rails to protect the resident and the Kerlix was a temporary fix until the hospice company provided a new bed.During an interview on 06/04/26 at 2:26 P.M., Patient Care Coordinator (PCC) #300, stated she was with the current hospice company. PCC #300 stated Resident #42 has half bed rails on her bed and had unknown bruising identified to her forehead. PCC #300 stated the half bed rails were supposed to have seizure pads applied to them to protect Resident #42 while in bed. During an email correspondence on 06/04/26 at 12:49 P.M., Chief Operating Officer (COO) #202 reported residents only used grab or assistance bars. COO #202 stated the facility did not have a separate policy related to rails, grab or assistance bars. COO #202 stated the facility utilized Restraint/Enabler Assessment tool for rails. Review of the June 2026 physician order summary report for Resident #42, revealed there were no orders for resident to have half side rails affixed to her bed and no physician orders to assess and monitor the resident for having side rails.Review of the facility policy titled, Healthcare Management Group, undated, confirmed the purpose of the policy was to identify acceptable reasons for the use of grab bars. The approved reasons included mobility assistance, transfer assistance, and safety during uncontrolled movement disorders. Further review of the policy confirmed side rails may not be used solely to prevent a resident from getting out of bed or restrict freedom of movement.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and staff interviews, the facility failed to ensure medical providers completed and signed their notes at the time of visit. This affected one (#45) of the three residents reviewed for provider visits. The facility census was 107.Findings include:Review of the medical record for Resident #45 revealed an admission date of 11/01/22. Diagnoses included chronic obstructive pulmonary disease (COPD), obsessive compulsive disorder (OCD), and type II diabetes mellitus (DM II).Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 had severely cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. Review of a physician progress note dated 04/07/26 for Resident #45 revealed the progress note was completed and signed on 06/03/26 at 11:42 A.M.During an interview on 06/03/26 at 10:29 A.M., Nurse Practitioner (NP) #200 verified she saw Resident #45 on 04/07/26 related to a hematoma to right shoulder but had not completed the progress note yet.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review, the facility failed to ensure appropriate infection control measures were followed during incontinence care. This affected one (#45) of three residents reviewed for urinary incontinence. The facility census was 107.Findings include:Review of the medical record for Resident #45 revealed an admission date of 11/01/22. Diagnoses included chronic obstructive pulmonary disease (COPD), obsessive compulsive disorder (OCD), and type II diabetes mellitus (DM II).Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #45 had severely cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was assessed to require partial assistance with eating, substantial assistance with toileting, bathing, and dressing, and setup with transfers. Review of section H for bowel and bladder of the Quarterly MDS assessment dated [DATE] revealed Resident #45 was frequently incontinent of bowel and bladder.Observation on 06/03/26 at 1:17 P.M. revealed Certified Nursing Assistant (CNA) #67 and CNA #81 completed incontinence care to Resident #45. During incontinence care, CNA #67 did not change gloves during care. CNA #67 proceeded to touch the resident, clean depends, and sheets with soiled gloves.During an interview on 06/03/26 at 1:32 P.M. with CNA #67 verified she did not change her gloves during incontinence care and touched Resident #45, clean depends, and sheets with soiled gloves.Review of the facility policy titled, Peri Care, dated 05/01/22 revealed to provide cleanliness and comfort to the resident, prevent infections and skin irritations, and observe the resident's skin condition. For cleansing the resident, use a clean area of cloth for each area cleansed. Remove gloves and perform hand hygiene. Apply clean gloves and apply clean brief and reapply clothing. Remove gloves and perform hand hygiene. Reposition resident into a safe and comfortable position and return bed to the lowest position.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy review the facility failed to ensure a safe, functional, sanitary and comfortable environment for the residents, staff and public. The affected all 45 residents housed on the East Unit. The facility census was 107. Findings include:Review of the medical record for Resident #59 revealed an admission date of 02/18/15. Diagnoses included major depressive disorder, bipolar disorder, and anxiety disorder Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had severely cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. Review of the medical record for Resident #60 revealed an admission date of 02/01/24. Diagnoses included obsessive compulsive disorder (OCD), schizoaffective disorder, bipolar type, and dementia. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #60 had intact cognition as evidenced by a BIMS score of 15 Observation of Resident #59 and #60's room on 06/03/26 at 12:22 P.M. with LPN #23, revealed the residents' room had several alive and dead flies throughout their room. During an interview with LPN #23 at the same time verified the flies in the residents' room. Observation the ceiling lights in the secured unit on 06/01/26 at 10:50 A.M. with Licensed Practical Nuse (LPN) #122 revealed nearly all the ceiling lights had copious amounts of visible dead bugs. During an interview with LPN #122 at the same time, verified the light covers had numerous dead bugs in them. Observation of the 200-unit hallway on 06/03/26 at 2:00 P.M. with LPN #05 revealed multiple ceiling lights had numerous dead bugs visible in the lights. During an interview with LPN #05 at the same time, verified multiple ceiling lights had numerous dead bugs visible in the lights. LPN #05 stated the dead bugs were also present during the recent annual survey in March 2026. Review of the facility policy titled, Homelike Environment, dated 05/01/22, revealed the residents are to be provided with a safe, clean, comfortable environment. The facility shall provide a clean, comfortable, and sanitary environment Review of the facility policy titled, Pest Control, dated 05/01/22 revealed the facility shall maintain a pest control program. The facility maintained an on-going pest control program and had pest control.