

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365894	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
NAME OF PROVIDER OR SUPPLIER MCV Health Care Facilities, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 411 Western Row Road Mason, OH 45040	
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** Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure resident dignity was maintained during medication administration. This affected one (#59) of five residents observed during medication administration. The facility census was 61. Findings include: Review of the medical record revealed Resident #59 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia, major depressive disorder, and anxiety disorder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had moderately impaired cognition and was dependent for toileting and bathing. Review of the care plan dated 06/03/25 for Resident #59 revealed the resident had impaired cognitive function or impaired thought processes related to dementia. Observation on 06/25/26 at 7:49 A.M. revealed Resident #59 was sitting in the common dining area with 13 other residents in the room. Resident #59 had two residents sitting at her table. Further observation revealed Registered Nurse (RN) #42 entered the room, lifted up Resident #59's shirt exposing her bare stomach, and administered an injection. Interview on 06/25/26 at 7:55 A.M. with RN #42 verified the injection for Resident #59 was given while in the common area. RN #59 stated nurses always administer medications, including injections, where ever the resident was at the time of administration. Interview on 06/25/26 at 8:45 A.M. with the Director of Nursing (DON) confirmed all administration of injections should be in a private area or resident room. Review of the undated facility policy titled, Resident Rights, revealed residents had the right to respect and dignity.		

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of pharmacy recommendations, staff interview, and policy review, the facility failed to ensure as needed psychotropic medications were not ordered for more than 14 days without adequate documented rationale. This affected one (#2) of five residents reviewed for unnecessary medications. The facility census was 61. Findings include: Review of the medical record for Resident #2 revealed an admission date of 12/23/25. Diagnoses included type II diabetes mellitus, major depressive disorder, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of ten. The resident was assessed to require setup with eating, was dependent with toileting, transfers, and dressing, and required substantial assistance with bathing. Review of the physician order dated 04/28/26 revealed Resident #2 was ordered Ativan one (1) milligram (mg) with instructions to give 1 tablet by mouth every four hours as needed for anxiety with no stop date. Further review of the order revealed no stop date was addressed in the order as of 06/24/26. There was no documented rationale for an extension of the medication beyond 14 days in the medical record. Review of the pharmacy recommendation in May 2026 revealed a recommendation that Resident #2's as needed Ativan needed a stop date, which required a discontinuation or a new order. Interview on 06/25/26 at 8:40 A.M. with the Director of Nursing (DON) verified the May 2026 pharmacy recommendation for Resident #2 was not followed and the resident's as needed Ativan order extended beyond 14 days without adequate documented rationale for continued use. Review of the undated facility policy titled, Psychotropic Medications, revealed physicians and mid-level providers would use psychotropic medications appropriately working with the interdisciplinary team (IDT) to ensure appropriate use, evaluation, and monitoring. The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits.		

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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 review of the medical record, staff interview, and policy review, the facility failed to ensure care conferences were completed in a timely manner. This affected one (#2) of two residents reviewed for care conferences. The facility census was 61. Findings include: Review of the medical record for Resident #2 revealed an admission date of 12/23/25. Diagnoses included type II diabetes mellitus, major depressive disorder, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of ten. The resident was assessed to require setup with eating, was dependent with toileting, transfers, and dressing, required and substantial assistance with bathing. Review of the care conference notes since admission revealed Resident #2 had only had one care conference dated 04/07/26. Interview on 06/25/26 at 10:38 A.M. with Social Worker Assistant (SWA) #36 revealed care conferences were to be completed quarterly. SWA #36 verified Resident #2 received one care conference since admission. Review of the undated facility policy titled, Care Conference Policy, revealed the facility was to ensure interdisciplinary communication, individualized care planning, discharge planning, and resident/family involvement. Care conferences would be conducted at least quarterly every three months for long-term care residents.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 pressure ulcers were thoroughly assessed and interventions were initiated to prevent pressure ulcer development for at risk residents. This affected one (#3) of two residents reviewed for pressure ulcers. The census was 61. Findings include: Review of the medical record for Resident #3 revealed an admission date on 06/01/26. Diagnoses included congestive heart failure (CHF), dysthymic disorder, major depressive disorder, osteoarthritis, pathological fracture, iron deficiency, insomnia, and fracture of the shaft of the left tibia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 13. The resident was assessed to require set up with eating, and was dependent with toileting, bathing, dressing, and transfers. Resident #3 was assessed with no pressure wounds on admission but was at risk for pressure wounds. Review of the nursing assessment/baseline care plan report dated 06/01/26 for Resident #3 revealed a skin tear on the right elbow and right antecubital, and bruising to the right hand (back), left antecubital, left elbow, left lower leg (front), right lower leg (front), and left lower leg front. Recommended interventions included the elevation of the heels, repositioning, and barrier cream. Review of an assessment used to predict pressure sore risk dated 06/01/26 revealed Resident #3 was at moderate risk. Review of the progress note dated 06/13/26 at 3:00 P.M., authored by Licensed Practical Nurse (LPN) #219, revealed Resident #3 had a discolored blister on his left heel. All parties were notified. A new order was received to apply an abdominal (ABD) pad for padding and protection to be changed three times a week and as needed until healed. Review of the treatment administration record (TAR) dated June 2026 for Resident #3 revealed no interventions were in place to float heels prior to 06/13/26. Review of the physician order dated 06/16/26 revealed Resident #3 was ordered Sage boots (padded boots) to bilateral heels when in bed two times a day. Review of the twice weekly skin assessment dated [DATE] for Resident #3 revealed a blister was identified but no measurements or description was provided. Interview on 06/24/26 at 2:56 P.M. with the Director of Nursing (DON) confirmed there was no mention of the blister to Resident #3's heel until 06/13/26 and no treatments were in place until 06/17/16, and measurements were not completed until 06/18/26. Follow up interview on 06/24/26 at 3:24 P.M. with the DON reported her expectation of staff for initial or new wounds was to measure the wounds. Interview on 06/25/26 at 12:11 P.M. with Medical Director (MD) #300 revealed her expectation for nursing staff was to measure and describe wounds, in detail, when they were first identified. Interview on 06/25/26 at 1:48 P.M. with Wound Nurse Practitioner (WNP) #305 revealed she expected staff to document and describe the wound in detail to help with monitoring the wound before she saw it with her weekly rounds. Review of the undated facility policy titled, Skin Care Policy and Procedure, revealed the purpose of the policy was to prevent and properly treat impaired skin. All residents are assessed upon admission and have daily skin assessments completed by a nurse for three days after admission. This is done by a nurse visually assessing a resident and completing the skin assessment form, a Braden scale assessment is completed, twice weekly skin assessments will be completed on the same schedule as showers.		

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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, medical record review, and policy review, the facility failed to ensure residents were free from potential hazards. This had the potential to affect three (#11, #33, and #37) of three residents on the Special Care Unit identified as independently mobile and cognitively impaired. The facility census was 61. Findings include:1. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE]. Diagnoses included altered mental status, chronic atrial fibrillation, unspecified dementia, and unspecified glaucoma. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had severely impaired cognition. Review of the care plan dated 03/30/26 revealed Resident #11 had impaired cognitive function, impaired thought processes, and was alert and oriented to self only. He was pleasantly confused related to altered mental status and unspecified dementia. 2. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia, other seizures, and altered mental status.Review of the most recent MDS assessment dated [DATE] revealed Resident #33 had severe cognitive impairment, was assessed to wander, and was dependent for toileting and bathing.3. Review of the medical record revealed Resident #37 was admitted to the facility on [DATE]. Diagnoses included Parkinsonism, dementia, anxiety disorder, cognitive social or emotional deficit, and major depressive disorder.Review of the most recent MDS assessment dated [DATE] revealed Resident #37 had moderately impaired cognition, disorganized thinking, and wandering behavior. Observation on 06/23/26 at 7:10 A.M. to 7:21 A.M. in the Special Care Unit (SCU) revealed the treatment cart next to the nursing area was unlocked with the right half door of the nursing station open and no staff were in sight anywhere in the common area. Further observation revealed eight residents were in the common area and three (#11, #33, and #37) of those residents were identified by the facility to be independently mobile.Interview on 06/23/26 at 7:22 A.M. with Licensed Practical Nurse (LPN) #41 confirmed the treatment cart was unlocked and the door to the nursing area was open to the common area. Interview and observation on 06/23/26 at 8:01 A.M. with the Director of Nursing (DON) of the treatment cart in the SCU hallway in common area confirmed multiple wound supplies including topical medications were in the cart. The DON also confirmed the items such as a bottle of liquid bleach, a bottle of liquid furniture polish, a spray bottle of laundry cleaner, a bottle of liquid disinfectant cleaner, and a bottle of liquid multi-surface cleaner were under the sink in an unlocked cabinet in the SCU nursing area during the observation.Review of the undated facility policy titled, Hazardous Chemical Storage and Security Policy (Memory Care Unit), revealed all hazardous chemicals shall be stored in locked cabinets or locked housekeeping closets when not in direct use and remain inaccessible to residents at all times.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, resident representative interview, and facility policy review, the facility failed to ensure foods were prepared and served to residents with the correct consistency. This affected three (#04, #11, and #48) of three residents reviewed moist and minced diet consistency. The total census was 61. Findings include: 1. Medical record review for Resident #11 revealed he was admitted to the facility on [DATE]. His diagnoses included glaucoma, pulmonary embolism, hypercholesteremia, chronic kidney disease, anemia, chronic atrial fibrillation, dementia, anxiety, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment for Resident #11 revealed he was cognitively impaired. Resident #11 required set up assistance from staff with his meals and oral hygiene. Resident #11 was dependent on staff for medication administration, toilet use, lower body dressing, bathing, and putting on shoes. Resident #11 required partial assistance from staff with upper body dressing. Review of Resident #11's care plan dated 06/12/26 revealed the resident was to receive a minced and moist diet. Interview with Resident #11's Resident Representative (RR) on 06/22/26 at 10:12 A.M. revealed the family was concerned with the consistency of the moist and minced diet provided to the resident. The RR revealed Resident #11's food appeared to be watered down and had a soupy appearance. Observation of the test tray at lunch on 06/24/26 at 12:15 P.M. with Dietary Manager (DM) #195 revealed the tray contained a moist and minced chicken patty that appeared very watered down and spread across the plate in with an oatmeal type consistency. The vegetable soup was smooth and had the consistency of a pureed diet. Interview with DM #195 on 06/24/26 at 12:15 P.M. confirmed the consistency of the chicken patty was not consistent with the moist and minced diet. DM #195 confirmed the consistency of the soup was relative to a pureed diet texture. 2. Medical record review for Resident #4 revealed she was admitted to the facility on [DATE]. Her diagnoses included insomnia, diabetes mellitus (DM), hypothyroidism, heart failure, essential primary hypertension, major depressive disorder, fibromyalgia, and dementia. Review of the MDS assessment, dated 06/10/26, for Resident #4 revealed she was cognitively impaired. Resident #04 was dependent on staff for eating, oral hygiene, medication administration, upper body dressing, lower body dressing, toilet use, personal hygiene, and bathing. Observation of the evening meal on 06/24/26 at 4:47 P.M. revealed Certified Nurse Aide (CNA) #13 assisted Resident #4 with her dinner. The turkey a la King was spread across the plate with a brown liquid ring. CNA #13 stirred the food prior to feeding it to Resident #4. Interview with CNA #13 on 06/24/26 at 4:47 P.M. confirmed she assisted Resident #4. CNA #13 confirmed Resident #4 required a minced and moist diet. CNA #13 revealed she continued to stir the food at a fast pace to try to thicken it up like a gravy because it appeared to runny. 3. Medical record review for Resident #48 revealed she was admitted to the facility on [DATE]. Her diagnoses included major depressive disorder, dementia, anxiety disturbance, and dysphagia. Review of the MDS assessment for Resident #48, dated 04/27/26, revealed she had impaired cognition. Resident #48 required set up assistance from staff with eating and putting on shoes. She required moderate assistance from staff with oral hygiene, bathing, upper body dressing, lower body dressing, toilet use, and personal hygiene. She was dependent on staff for medication administration. Observation of Resident #48 on 06/24/26 at 4:49 P.M. revealed CNA #32 assisted Resident #48 with her meal. Interview on 06/24/26 at 4:49 P.M. with CNA #32 confirmed the turkey a la King on Resident #48's meal was very runny and spread across the plate. Review of the undated facility policy titled, Minced & Moist Procedure Guide, confirmed the goal (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was for food to be very soft, moist, and have some small chopped, lumpy or minced texture. In most food items, the food should stay on the fork and have minimal liquid separation. House minced and moist will consist of small chopped or minced or pulsated mechanical soft foods that may be combined with same puree food item to reach soft, lumpy, moist consistency. In most cases, little to no liquid should sperate from minced and moist foods.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 drinks were stored and served at an appropriate temperature. This affected three (#33, #41, and #44) of three residents the facility identified who ingested milk that was out of temperature range. The facility census was 61. Findings include: Observation and interview on 06/24/26 at 8:02 A.M. of the Memory Care Unit (MCU) refrigerator, with Director of Maintenance (DOM) #135, revealed the thermometer measured 48 degrees Fahrenheit (F). DOM #135 confirmed the temperature of the refrigerator and stated the food was not cold to touch. Interview and observation on 06/25/26 from 8:05 A.M to 8:30 A.M with Dietician #295 and Dietary Manager (DM) #195 revealed temperature checks of drinks from the refrigerator included milk that was in the door measured 46.7 degrees F and a gallon of milk on the middle shelf measured 51 degrees F. Dietician #295 and DM #195 confirmed all of the items that require refrigeration would be thrown out. Interview on 06/25/26 at 8:35 A.M. with Certified Nurse Aide (CNA) #32 confirmed Resident #33, Resident #41, and Resident #44 consumed milk out of the refrigerator unit that were not in acceptable temperature range. Review of the undated policy titled, Food Handling and Storage, revealed all refrigerated foods should be stored at a temperature between 32 degrees and 41 degrees.		

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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 observation, staff interview, medical record review, and policy review, the facility failed to ensure staff providing direct care to residents with enhanced barrier precautions wore appropriate personal protective equipment during the delivery of care. This affected one (#3) of five residents reviewed for infection control precautions. The facility census was 61. Findings include: Medical record review for Resident #3 revealed he was admitted to the facility on [DATE]. His diagnoses included congestive heart failure (CHF), dysthymic disorder, major depressive disorder, osteoarthritis, pathological fracture, iron deficiency, insomnia, and fracture of the shaft of the left tibia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact. Review of the orders for Resident #3 revealed an order dated 06/01/26 for urinary catheter care. Review of the orders for Resident #3 dated 06/18/26 revealed the resident was ordered treatment to a left heel wound to include application of betadine, cover with a dry dressing, and wrap with Kerlix. Review of the care plan dated 06/21/26 for Resident #3 revealed no goal or intervention for enhanced barrier precautions (EBP) and review of all current orders for June 2026 revealed no order for EBP. Observation on 06/24/26 between 11:18 A.M. and 11:33 A.M. revealed Registered Nurse (RN) #105 completed wound care to Resident #3's left heel in his room without wearing a gown. RN #105 walked out of the room to get scissors and proceeded back into Resident #3's room again with no gown and completed the dressing change. Observation of the EBP sign outside of Resident #3's door indicated for caregivers to wear gloves and a gown for high-contact resident care activities including dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, device care or use, and wound care. Interview on 06/24/26 at 11:40 A.M. with RN #105 stated she did not normally wear gowns during wound care, only with open wounds. RN #105 confirmed the EBP sign at Resident #3's room. RN #105 stated her supervisor told her no gown was needed for care. Interview on 06/24/26 at 2:26 P.M. with the Director of Nursing (DON) revealed Resident #3 did not have an active order for EBP or have it in the care plan. The DON stated Resident #3 was in EBP and staff should be following the policy. Review of the facility policy titled, Enhanced Barrier Precautions, dated 2024, revealed an order for EBP will be obtained for residents with any of the following including chronic wounds and indwelling medical devices.		