STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366142	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Run Care Center	3399 Mill Run Drive Hilliard, OH 43026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interview, the facility failed to ensure a resident received a discharge summary and medications necessary for a safe and effective transition following discharge. This affected one (#56) out of three residents reviewed for the discharge process. The facility census was 54. Findings include: Review of the medical record for Resident #56, revealed an admission date of 04/09/26 and discharge date of 05/14/26. Diagnoses included malignant neoplasm of lower lobe of left bronchus or lung, depression, intervertebral disc degeneration of lumbar region with discogenic back pain and lower extremity pain. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #56 had a Brief Interview for Mental Status score of 15 indicating intact cognition and no behavioral concerns were identified. Review of discharge planning documentation dated 05/13/26 revealed Resident #56's discharge was planned for 05/14/26 with arrangements for transportation via Provide a Ride at 9:00 A.M. and home health services. The resident was anticipated to discharge to home. Review of physician orders and discharge documentation revealed discharge orders were completed on 05/14/26. The discharge medication list included multiple medications related to respiratory disease, pain management, cardiac conditions, gastrointestinal care, and routine maintenance therapies. The discharge summary was completed but was not signed by Resident #56 prior to the resident's departure/discharge. Review of progress notes dated 05/14/26 at 9:31 A.M. revealed nursing documentation stating the resident was ready for discharge and requested assistance with belongings. The nurse documented she informed the resident she was retrieving discharge medications and paperwork. The nurse further documented that upon return the resident had already left the facility via arranged transportation prior to receiving discharge medications or discharge paperwork. Review of the medication administration record and discharge medication list revealed multiple medications were discontinued effective 05/14/26 including inhalers, anticoagulation related therapies, pain medications, gastrointestinal medications, and chronic disease management medications. Documentation did not reflect that medications were sent with the resident, delivered to the pharmacy, or mailed after discharge. Review of discharge records revealed the resident did not sign discharge paperwork prior to leaving the facility. Staff signatures were later applied to documentation after the resident's departure/discharge. There was no documentation that discharge paperwork or prescriptions were mailed or otherwise delivered to Resident #56 after discharge. Review of post discharge follow up documentation revealed only one documented contact attempt from the Director of Nursing on 05/15/26. No additional documented attempts were made by nursing, social services, or administration to contact Resident #56 following discharge. Review of facility records revealed no documentation that the resident's primary care provider was notified that Resident #56 left the facility without discharge medications or instructions. There was no documentation that the home health agency was notified of missing discharge instructions or medication reconciliation needs. There was no documentation that prescriptions were sent to a pharmacy or otherwise arranged for post discharge access other than the facility anticipating a return from the resident to pick the items directly up from the medication storage room. Interview with (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
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56 on 06/11/26 at 10:07 A.M. revealed she stated she did not receive a phone call after leaving the facility regarding her discharge medications or discharge paperwork. Resident #56 stated she was informed prior to discharge that medications and paperwork would be sent or mailed, but she did not receive either at her home address. Resident #56 stated she did not receive discharge medications, prescriptions, or follow up communication from the facility after leaving on 05/14/26. Interview with Registered Nurse (RN) #123 on 06/11/26 at 10:18 A.M. revealed she was responsible for completing discharge preparation for Resident #56. RN #123 stated she left the unit to retrieve discharge medications while the resident was waiting for transport. RN #123 stated when she returned the resident had already left the facility. RN #123 confirmed the resident did not sign discharge paperwork prior to leaving. RN #123 stated discharge medications were left in the medication room and were not sent with the resident or otherwise arranged for delivery. RN #123 further confirmed she did not contact the physician regarding the resident leaving without medications. Interview with Licensed Practical Nurse (LPN) #110 on 06/11/26 at 10:28 A.M. confirmed Resident #56 left the facility without discharge paperwork or medications. LPN #110 stated she immediately notified social services after the resident's departure. Interview with Social Worker (SW) #188 on 06/11/26 at 10:36 A.M. revealed discharge planning had been completed in advance with transportation scheduled for 9:00 A.M. SW #188 stated Resident #56 left the facility between 9:00 A.M. and 9:30 A.M. SW #188 confirmed that after discharge staff attempted to contact the resident but no response was received. SW#188 confirmed there was no documented communication with the primary care provider or home health agency regarding missing discharge medications or instructions. SW #188 further stated medications were not sent to a pharmacy and remained at the facility with the expectation the resident could return to retrieve them. Interview with Director of Nursing (DON) and Regional Staff #200 on 06/11/26 at 12:43 P.M. and 2:02 P.M. confirmed there was only one documented follow up attempt after Resident #56's discharge on [DATE]. They confirmed there was no documentation that the primary care provider, home health agency, or pharmacy were notified that Resident #56 left without discharge medications or instructions. They confirmed medications were retained at the facility and were not delivered, mailed, or transmitted to a pharmacy. They further confirmed the facility did not ensure completion of discharge medication delivery or continuity of care after the resident left. This deficiency represents non-compliance investigated under Complaint Number 3022352.