

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/12/2025
NAME OF PROVIDER OR SUPPLIER  Mason Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5640 Cox-Smith 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)
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed and transmitted within 14 days. This affected two (Residents #401 and #402) of six residents reviewed for assessments. The facility census was 38 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #401 revealed an admission date of 03/29/25 with diagnoses including cellulitis of the left finger, asthma, and type two diabetes mellitus and a discharged from the facility on 04/21/25.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #401 dated 04/04/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.)</p> <p>Review of the discharge return anticipated (DRA) MDS assessment for Resident #401 dated 04/19/25 revealed the MDS was in progress and had not been transmitted.</p> <p>Review of the progress note for Resident #401 dated 04/19/25 timed at 11:42 A.M. revealed the resident's representative called the urologist and was instructed to take the resident to the emergency room (ER). Resident #401 left the facility with two friends and his representative in an automobile.</p> <p>Review of the progress note for Resident #401 dated 04/20/25 timed at 7:18 P.M. revealed the resident returned to the facility at 6:50 P.M.</p> <p>Review of the DRA MDS assessment for Resident #401 dated 04/21/25 revealed the MDS was in progress and had not been transmitted.</p> <p>Review of the progress note for Resident #401 dated 04/21/25 timed at 11:55 A.M. revealed the resident had discharged home.</p> <p>Interview on 05/12/25 at 3:46 P.M with MDS Licensed Practical Nurse (LPN) #215 confirmed the DRA MDS assessments dated 04/19/25 and 04/21/25 for Resident #401 had not been transmitted within 14 days as required.</p> <p>(continued on next page)</p>

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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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #402 revealed an admission date of 07/11/24 with diagnoses including cerebral infarction, generalized anxiety disorder, major depressive disorder, and a discharge date of 04/30/25.</p> <p>Review of the admission MDS assessment for Resident #402's dated 01/16/25 revealed the resident was cognitively intact and required assistance with ADLs.</p> <p>Review of the quarterly MDS assessment for Resident #402 dated 04/18/25 revealed the MDS was in progress and had not been transmitted.</p> <p>Review of the DRA MDS assessment for Resident #402 dated 04/30/25 revealed the MDS was in progress and had not been transmitted.</p> <p>Review of the progress note for Resident #402 dated 04/30/25 timed at 7:38 P.M. revealed the resident was transported to the emergency room (ER).</p> <p>Interview on 05/12/25 at 3:46 P.M with MDS LPN #215 confirmed the quarterly MDS assessment dated [DATE] and the DRA MDS assessment dated [DATE] for Resident #402 had not been transmitted within 14 days as required.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, staff interview, and review of the facility policy, the facility failed to ensure medications in the medication cart were labeled and stored in proper containers. This affected all of the residents residing in the facility. The facility census was 38 residents.</p> <p>Findings include:</p> <p>Observation on 05/12/25 at 9:00 A.M of the nurse two medication cart on the skilled care hallway revealed there were 19 loose pills of various shapes and colors in the bottom of the medication cart.</p> <p>Interview on 05/12/25 at 9:00 A.M. with Registered Nurse (RN) #221 confirmed there were 19 loose pills of various shapes and colors in the bottom of the nurse two medication cart on the skilled care hallway. RN #221 confirmed she was not able to identify the 19 pills nor to whom the 19 pills were prescribed.</p> <p>Observation on 05/12/25 at 9:26 A.M of the nurse two medication cart on the long-term care hallway revealed there were 92 loose pills of various shapes and colors in the bottom of the medication cart.</p> <p>Interview on 05/12/25 at 9:26 A.M with RN #221 confirmed there were 92 loose pills of various shapes and colors in the bottom of the nurse two medication cart on the long-term care hallway. RN #221 confirmed she was not able to identify the 92 pills nor to whom the 92 pills were prescribed.</p> <p>Observation on 05/12/25 at 9:32 A.M of the nurse one medication cart on the long-term care hallway revealed there were 130 loose pills of various shapes and colors in the bottom of the medication cart.</p> <p>Interview on 05/12/25 at 9:32 A.M with Licensed Practical Nurse (LPN) #224 confirmed there were 130 loose pills of various shapes and colors in the bottom of the nurse one medication cart on the long-term care hallway. LPN #224 confirmed she was not able to identify the 130 pills nor to whom the pills were prescribed.</p> <p>Review of the facility policy titled Medication Storage dated November 2021 revealed drugs should dispensed and stored in the manufacturer's original container.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00165462.</p>		