STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366375	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masternick Memorial Health Care Center	5250 Windsor Way New Middletown, OH 44442

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 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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, interview, facility investigation review and facility policy review, the facility failed to ensure Resident #52 did not leave the facility without staff knowledge. This affected one (Resident #52) of three residents reviewed for elopement. The facility identified nine (Residents #6, #42, #52, #56, #64, #69, #70, #72 and #73) at risk for elopement. The facility census was 82.Findings include:Review of the medical record for Resident #52 revealed an admission date of 10/01/25. Diagnoses included dementia, hypertension, anxiety, and skin cancer.Review of the elopement risk evaluation dated 10/01/25 revealed Resident #52 was not at risk for elopement.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was severely cognitively impaired. He required help for eating, supervision for oral care, dressing, hygiene and toileting and partial assistance for showering. He was independently mobile.Review of the physicians' orders for January 2026 revealed Resident #52 had been wearing a Wanderguard (a bracelet worn on the wrist or ankle of a resident to alert staff if they try to leave the building) which was ordered on 10/02/25.Review of the nursing progress note dated 11/17/25 at 7:16 P.M. revealed at approximately 11:00 A.M., nursing staff received a phone call from a female who was driving in the area and spotted Resident #52 walking in the community. An elopement code was called, and two staff were sent by a car to the area where the resident was seen. Emergency services were also called and were en route to the location where the resident was last seen. At 11:14 A.M. the resident was located by police and emergency medical services (EMS), and the resident was returned to the facility. The physician was notified and a head-to-toe assessment was completed. Resident #52 was placed on one-to-one supervision. Resident #52's vital signs included blood pressure 149/75, heart rate 61, pulse ox 99% on room air, temperature 97.5 degrees Fahrenheit (F) and respirations 16.Interview on 02/05/26 at 7:47 A.M. with the Administrator revealed the facility received a phone call from the police that Resident #52 was walking down the street, and they were bringing him back. The facility assessed the situation and determined Resident #52 broke the screw that secured his window in his room, removed the screen from his window and placed it under his bed and climbed out his bedroom window. She revealed the last time he was seen was shortly after breakfast, at approximately 8:40 A.M. The call that he was found came in approximately an hour and a half later.Review of the facility investigation dated 11/17/25 revealed Resident #52 was last seen by a staff at approximately 8:40 AM. He was observed walking to his room, lying on his bed and shutting his door, which was his normal routine. Resident #52 resided on the secured memory care unit and had a Wanderguard in place beginning from admission. Resident #52 went out his bedroom window and broke the safety screw off the window and removed the screen. The temperature was identified as 40 degrees F. Resident #52 was wearing a sweatshirt and T-shirt, long pants and shoes. Resident #52 was located approximately 2.5 miles from the facility. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility notified the local police department, the physician, the power of attorney (POA) and immediately conducted an elopement code. The resident was returned to the facility by local police, and a head-to-toe assessment was completed. No injuries were noted; Resident #52 was placed on one-to-one supervision. Resident #52 stated he went out the window and was going away. He returned to the facility with a pillowcase and shopping bag of personal items including washcloths, towels, and clothing.Interview on 02/05/26 at 12:41 P.M. with Licensed Practical Nurse (LPN) #201 says a friend of Resident #52's called the facility and said they saw him walking down the street. She revealed facility staff immediately started looking for him and called EMS who brought him back in. She revealed there was nothing remarkable about his behavior that day, he was calm, pleasant and cooperative. She said it was common for him to stay in his room with the door closed and was independent in most of his activities of daily living (ADL). She revealed he made no mention of being agitated or wanting to leave the day he eloped.Interview on 02/05/26 at 1:07 P.M. with the Certified Nurse Aide (CNA) #202 confirmed Resident #52 went to his room to lie down after breakfast at approximately 8:40 A.M. She also confirmed he was independent with most of his ADL, and was last seen at approximately 8:40 A.M.Interview on 02/05/26 at 1:26 P.M. with the Administrator confirmed the facility had been taking additional measures to address any future potential elopements.Review of the facility policy titled Wandering/Elopement, dated October 2025, revealed an elopement was defined as a resident leaving a home or safe area without the facilities knowledge or without supervision. If a resident eloped, the facility would immediately follow a missing person's procedure and document the elopement.The deficient practice was corrected on 11/18/25 when the facility implemented the following corrective actions: - Immediately upon return to the facility, Resident #52 was assessed by LPNs #201 and #204 and no negative outcomes or injuries were noted. - On 11/17/25, Resident #52's bedroom window was resecured by Maintenance Director #205 and Activity Director #206. - On 11/17/25, the facility interviewed all staff working at the time of the incident RN #207 and the Director of Nursing (DON).- On 11/17/25 all residents with Wanderguards were checked to ensure they were in place and functioning by Registered Nurse (RN) #207.- On 11/17/5, all windows on the secured unit were rechecked to ensure they were secured by the DON and Activity Director #206.- On 11/17/25, all residents' elopement evaluations were reviewed by the DON and LPN #208.- On 11/17/25, all elopement books were reviewed for accuracy by RN #207.- On 11/17/25, all facility staff were re-educated on the wandering/elopement and abuse/neglect policies by RN #207, the DON and the Administrator.- Beginning on 11/17/25, all windows on the secured unit were checked for security daily for five days per week for two weeks by the DON, the Administrator, and LPN #209. - Beginning 11/18/25, elopement drills were completed three times per week on varying shifts for four weeks by RN #207, the DON, and the Administrator.- An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held on 11/18/25 to review the occurrence. This deficiency represents noncompliance investigated under complaint number 2684732.