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	05/29/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record reviews and staff interviews, the facility failed to ensure confidentiality of residents' protected health information. This affected 12 of 12 residents (#30, #57, #90, #91, #92, #93, #94, #95, #96, #97, #98 and #99) reviewed for confidentiality of records. The census was 84. Findings include:Review of an email dated 04/30/26 and timed at 4:41 P.M. to Administrator from Resident #20's son revealed he was notifying the facility of the breach of protected health information. He stated the facility sent a total of 786 pages on 04/29/26 at 3:34 P.M. that included information on 12 other residents. He did not disclose the names in this email. He requested the Administrator forward the email to the Privacy Office/Compliance Officer.Interview on 05/29/26 at 1:06 P.M. with Administrator and Quality Assurance Nurse (QAN) #220 verified there was a breach of protected health information of 12 residents on 04/28/26 when the facility scanned requested medical information for Resident #20 to his son. Resident #20's son discovered other residents' information amongst his father's medical record and informed the facility via email.A skilled progress note including protected health information for each of the following residents was sent to Resident #20's son along with his father's requested information: Resident #30, Resident #57, Resident #90, Resident #91, Resident #92, Resident #93, Resident #94, Resident #95, Resident #96, Resident #97, Resident #98, and Resident #99,Interview on 05/29/26 at 2:57 P.M. with Managed Care Coordinator (MCC) #250 verified she was the one who scanned other residents' information while fulfilling the release of medical records request from Resident #20's son. She stated she had printed a report from their electronic medical record (EMR) by typing the first few letters of Resident #20's name. She stated it printed to her printer and saw Resident #20's name on the top page. She scanned the information in a secured email to Resident #20's son. After discovering the breach, the facility determined multiple residents' were selected while printing the report. MCC #250 stated Resident #20's names was on top (alphabetically) and she did not think to look at the rest of the pages.Review of the facility policy titled Protected Health Information HIPAA Control Policy, dated 10/2013, revealed it was the policy of this facility to handle, store, and communicate our residents and employees protected health information (PHI) in accordance with current federal, state, and local regulations. The facility was to assure that release of PHI was only done by staff authorized to do so and that request/release were logged.The deficient practice was corrected on 05/06/26 when the facility implemented the following corrective actions: -Corporate QA (QAN #220) audited residents' documents on 04/30/26 to ensure only the resident's documents were in the chart.-Ad hoc QAPI completed on 05/01/26 which included the Medical Director to review the Abuse/neglect policy.-All staff were educated on HIPAA policy and abuse policy from 05/01/26 through 05/06/26.-Managed Care Coordinator (MCC) #250 was in-serviced by Administrator on 04/30/26 on HIPAA and Privacy policy.-All affected residents and resident representatives were notified of breach via phone and in writing by the facility and QAN #220 on 05/01/26. There were no concerns voiced by residents or resident representatives.-QAN #220 reported HIPAA breach to the Civil Rights Department on 05/05/26.-Medical Records #200 audited five days a week for four weeks to ensure medical records uploaded into EMR were uploaded to the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	correct resident.This deficiency represents non-compliance investigated under Complaint Number 3011361.