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	03/06/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure Resident #146's allegation of misappropriation of personal property was promptly reported to the state agency as required. This affected one resident (Resident #146) of two residents reviewed for misappropriation of personal property. The facility census was 80. Findings include: Review of Resident #146's medical record revealed the resident was admitted on [DATE] and discharged home on 11/23/24 with diagnoses including displaced fracture of the olecranon process, bipolar disorder and need for assistance with personal care. Review of Resident #146's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #146's Missing Items Report form dated 11/22/24 revealed the Social Worker and Administrator spoke with the resident in his room. Resident #146 provided a description of a missing item as a gold chain with cross. Resident #146 stated a male aid was in his room around 7:00 P.M. on 11/19/24 and offered to move items from a nightstand to the bathroom. Resident #146 declined and used the restroom between 7:50 P.M. and 8:00 P.M. and stated the necklace was missing. Resident #146 stated the male Certified Nursing Assistant (CNA) never returned to his end table and he notified staff immediately by call light. Review of the Witness Statement form dated 11/21/24 and authored by Certified Occupational Therapy Assistant (COTA) #915 revealed at 2:00 P.M. on 11/19/24, Resident #146 was returned to his room, and his crucifix necklace was on the nightstand by the bed. Review of the Witness Statement form dated 11/21/24 authored by Nurse Aide Supervisor (NAS) #812 revealed CNA #859 was interviewed over the phone. CNA #859 stated the last time he had observed the crucifix necklace was when he had toileted the resident and noticed the resident's neck was extremely red and irritated. He asked the resident if he wanted to take off the necklace to relieve the irritation it caused, and the resident agreed. CNA #859 said the necklace was placed on the bathroom sink. CNA #859 stated the last time he was in Resident #146's room was around 7:00 P.M. to empty the bathroom trash. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NAS #812 was unable to be obtained due to NAS #812 being on vacation at the time of the survey. Interview on 03/03/25 at 12:00 P.M. with the Administrator revealed she spoke to Resident #146's sister about the missing necklace and then spoke to Resident #146 who identified CNA #859 as the aid who misplaced or took the necklace as this was the last person to have the necklace. The Administrator stated she interviewed CNA #859 who had reported he took the necklace off Resident #146 because it was rubbing the resident's neck. The Administrator confirmed CNA #859 placed the necklace on the bathroom sink and then the necklace was moved for some reason to the resident's nightstand where it disappeared. The Administrator confirmed she was unable to find the necklace. An additional interview on 03/03/25 at 2:08 P.M. with the Administrator indicated she did not realize she was supposed to file a misappropriation Self-Reported Incident (SRI) with the state agency for Resident #146's missing necklace. Telephone interview on 03/03/25 at 2:51 P.M. with CNA #859 stated he helped Resident #146 take off his necklace and had observed the resident lay the necklace in the sink. CNA #859 denied he lost the necklace, threw the necklace away or took the necklace home. He was unaware of what happened to the necklace after his shift ended. Review of the facility policy titled Abuse Allegation Investigation, dated 10/2022, revealed the facility administrator or his/her designee will ensure the allegation was reported to the State Agency and if the allegation/incident was a suspected crime, reported to law enforcement as outlined in the Suspected Crimes policy. This deficiency represents non-compliance investigated under Complaint Number OH00161951.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure an allegation of misappropriation of resident property was throughly investigated for Resident #146. The affected one resident (Resident #146) of two residents reviewed for misappropriation. The facility census was 80. Findings include: Review of Resident #146's medical record revealed the resident was admitted on [DATE] and discharged home on 11/23/24 with diagnoses including displaced fracture of the olecranon process, bipolar disorder and need for assistance with personal care. Review of Resident #146's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #146's Missing Items Report form dated 11/22/24 revealed the Social Worker and Administrator spoke with the resident in his room. Resident #146 reported a missing gold chain with cross. Resident #146 indicated a male Certified Nursing Assistant (CNA) was in his room around 7:00 P.M. on 11/19/24 and offered to move items from the nightstand to the bathroom. The resident declined and used the restroom between 7:50 P.M. and 8:00 P.M. and the necklace was missing. Resident #146 stated the male CNA never returned to his end table and he notified staff immediately by call light. Review of the facility investigation documents provided by the facility and dated 11/21/24 through 11/25/24 revealed no interviews with other residents were conducted to see if other residents may have had details regarding the allegation. The only resident interview conducted was with Resident #146. Review of the Witness Statement form dated 11/21/24 and authored by Certified Occupational Therapy Assistant (COTA) #915 revealed at 2:00 P.M. on 11/19/24, the resident was returned to his room, and his crucifix necklace was on the nightstand by the bed. Review of the Witness Statement form dated 11/21/24 and authored by Nurse Aide Supervisor (NAS) #812 revealed the CNA #859 was interviewed over the phone. CNA #859 stated the last time he had observed the crucifix necklace was when he had toileted the resident and noticed the resident's neck was extremely red and irritated. He asked the resident if he wanted to take off the necklace to relieve the irritation it caused, and the resident agreed. CNA #859 said the necklace was placed on the bathroom sink. CNA #859 stated the last time he was in Resident #146's room was around 7:00 P.M. to empty the bathroom trash. Interview on 03/03/25 at 12:00 P.M. with the Administrator indicated she spoke to Resident #146's sister about the missing necklace and then spoke to Resident #146 who stated CNA #859 misplaced or took the necklace as this was the last person to have the necklace. The Administrator stated she interviewed CNA #859 who had reported he took the necklace off Resident #146 because it was rubbing the resident's neck. The Administrator confirmed CNA #859 placed the necklace on the bathroom sink and then the necklace was moved for some reason to the resident's nightstand where it disappeared. The Administrator confirmed she was unable to find the necklace. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional interview on 03/03/25 at 2:08 P.M. with the Administrator indicated she did not realize she was supposed to file a misappropriation Self-Reported Incident (SRI) with the state agency for Resident #146's missing necklace. She confirmed Resident #146 and the resident's family were the only resident interviews completed during the investigation. Review of the facility policy titled Abuse Allegation Investigation, dated 10/2022, revealed the facility would immediately investigate all allegations and interview all residents that may have details regarding the allegation. This deficiency represents non-compliance investigated under Complaint Number OH00161951.