CENTERS FOR MEDICARE & MEDICAID SERVICES	DEPARTMENT OF HEALTH AND HUI	MAN SERVICES
	CENTERS FOR MEDICARE & MEDIC	AID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155003		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey eted /2022	
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD		
MASON HEALTH CARE CENTER				WARSA	AW, IN 46580		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
E 0000	indeed.ireiti er						5.112
E 0004 SS=F Bldg	conducted by the In accordance with 42  Survey Date: 11/02  Facility Number: 0  Provider Number: 1002  At this Emergency Itelath Care Center with Emergency Promedicare and Mediand Suppliers, 42 Comparison of the Survey, the censurvey, the censurv	2/22  00003 155003 290600  Preparedness survey, Mason was found not in compliance eparedness Requirements for caid Participating Providers FR 483.73  certified beds. At the time of us was 86.  Inpleted on 11/10/22  4(a), 418.113(a), 5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),	E 00	000	The creation and submission Plan of Correction does not constitute an admission by the provider of any conclusion see in the statement of deficienci any violation or regulation. We requesting paper compliances Please see supporting documentation attached.	is et forth es, or e are	
	The [facility] must Federal, State and	comply with all applicable d local emergency					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Rukiya Brooks Administrator 11/23/2022

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155003		A. BUILDING B. WING		COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIER HEALTH CARE CE		900 PR	ADDRESS, CITY, STATE, ZIP COD ROVIDENT DRIVE AW, IN 46580	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	preparedness required must develop estate comprehensive errorgram that meet section. The emer program must include the following elem  (a) Emergency Pladevelop and maining preparedness plar and updated at least must do all of the section. The emergency Plane is the section of	uirements. The [facility] ablish and maintain a nergency preparedness ts the requirements of this gency preparedness ude, but not be limited to, ents:  an. The [facility] must tain an emergency that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or up and maintain a nergency preparedness ts the requirements of this an all-hazards approach.  es at §483.73(a):] The LTC facility must tain an emergency that must be reviewed, ast annually.  ities at §494.62(a):] The ESRD facility must tain an emergency that must be [evaluated],	TAG	DEFICIENCY	DATE
	failed to review and	riew and interview, the facility update the Emergency EPP) at least annually in	E 0004	what corrective action(s     be accomplished for those     residents found to have been	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ ´	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155003	B. WING COMPLETED 11/02/2022				
					ADDRESS, CITY, STATE, ZIP COD	.,,52/	
NAME OF P	PROVIDER OR SUPPLIEF				OVIDENT DRIVE		
MASON	HEALTH CARE CE	NTER	_		AW, IN 46580		
(X4) ID		UMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		CFR 483.73(a). This deficient	+	TAG	affected by the deficient practi	ce.	DATE
	practice could affect	* *			ancolou by the denoicht practi	00,	
	Findings include:				The emergency preparedness plan has been reviewed and updated by		
	Based on records review with the Administrator and Maintenance Director on 11/02/22 at 10:01 a.m., the EEP cover page showed the last review date was 01/01/20, no other documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Administrator				management and all staff		
					members. We have updated e	every	
					preparedness book in the build	ding.	
					2. how other residents have	ina	
					the potential to be affected by	-	
	and Maintenance D				same deficient practice will be		
		now the EEP was reviewed or			identified and what corrective		
	updated within the	last year could not be found.			action(s) will be taken;		
	This finding was re	viewed with the Administrator			Emergency		
	-	irector during the exit			preparedness plan was review	ved	
	conference.				by all staff to be updated into		
					current status.		
					what measures will be p into place and what systemic	ut	
					changes will be made to ensu	re	
					that the deficient practice does		
					recur;		
					The emergency preparedness will be reviewed annually with staff.		
					4 how the correction and	2(0)	
					4. how the corrective action will be monitored to ensure the	` ,	
					deficient practice will not recui	_	
					i.e., what quality assurance	,	
					program will be put into place;	and	
					- The emergency preparedness	;	
					book will be placed at all nursi	ng	
					stations and reviewed annuall	y by	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155003	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <del></del>	COM	TE SURVEY PLETED 02/2022
	PROVIDER OR SUPPLIEF		900 PF	ADDRESS, CITY, STATE, ZIP ROVIDENT DRIVE AW, IN 46580	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
				staff. All new hires will on the emergency pre book.		
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.920(b), §486 §494.62(b).  (b) Policies and properties an	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 3.54(b), §418.113(b), 2.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §491.12(b), 6.360(b), 6.360(b), §491.12(b), 6.360(b), 6.360(				
	*Additional Requir	ements for PACE and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155003		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X	c3) date survey COMPLETED 11/02/2022			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 900 PROVIDENT DRIVE WARSAW, IN 46580				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE ID ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX GULATORY OR LSC IDENTIFYING INFORMATION TAG Facilities:		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	*[For PACE at §46 procedures. The develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication placetion. The policiaddress manager nonmedical emerglimited to: Fire; equal failure; care-related disasters likely to safety of the partice. The policies and previewed and updown to the emergency (a) of this section, paragraph (a)(1) of communication placetion. The policies and procedures. (a) of this section, paragraph (a)(1) of communication placetion. The policies emergency (a) implementation placetion. The policies emergency (b) implementation placetion. The policies emergency (a) implementation placetion. The policies reviewed and updayears. These emergency (a) implementation placetion implementation placetion in the policies of the particular placetion in the policies of the particular placetion in the policies of the particular placetic placeti	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be ated at least every 2 years.  Ities at §494.62(b):] Policies The dialysis facility must ement emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 ergencies include, but are equipment or power ted emergencies, water in, and natural disasters ine facility's geographic					
	failed to review and Preparedness Plan (	riew and interview, the facility I update the Emergency EPP) Policies and Procedures accordance with 42 CFR	E 0013	what corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice.			

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CENTERS FOR	R MEDICARE & MEDIC	AID SEKVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155003	B. WING		11/02/2022
MASON (X4) ID		NTER STATEMENT OF DEFICIENCIE	900 PR WARSA	ADDRESS, CITY, STATE, ZIP COD ROVIDENT DRIVE AW, IN 46580  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
	,			CROSS-REFERENCED TO THE APPROPRIA	NIE .
PREFIX TAG	(EACH DEFICIEN REGULATORY OR 483.73(a). This define occupants.  Findings include:  Based on records reand Maintenance Da.m., the EEP cover date was 01/01/20, be found to show the were reviewed and Based on an interviewed and Based on an interviewed and the documentation to Procedures were reviewed not be sometimes of the documentation of the state of the	exist of the Administrator could after all review with the Administrator could after all review of the Administrator could represent the Admin	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	completion DATE  ve and  ing the second the
				updates.  4. how the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;  Emergency preparedness boo will be reviewed annually	e r, ; and

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155003		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVET  A. BUILDING COMPLETED  B. WING 11/02/2022			ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 900 PROVIDENT DRIVE WARSAW, IN 46580				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0029 SS=F Bldg	484.102(c), 485.6: 485.727(c), 485.9: 491.12(c), 494.62: Development of C §403.748(c), §416: §441.184(c), §466: §483.73(c), §485.9: §485.68(c), §485.9: §494.62(c).  (c) The [facility] m an emergency preplan that complies local laws and mulat least every 2 years failed to review and Preparedness Plan (least annually in acceptance of the process of th	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan 5.54(c), §418.113(c), 2.84(c), §482.15(c), 475(c), §484.102(c), 525(c), §485.727(c), 2.360(c), §491.12(c), 2.360(c), 2.	E 00	29	1. what corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. All staff has been updated on a emergency preparedness plans Staff has been instructed on we to find the policy and procedure.  2. how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  The facility will continue to train and update staff on the policy procedures.  3. what measures will be presented.	ce; the n. vhere res. ng the	11/22/2022

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039	
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155003		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIEF			900 PR	ADDRESS, CITY, STATE, ZIP COD ROVIDENT DRIVE AW, IN 46580			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
me	This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			mo	into place and what systemic changes will be made to ensu that the deficient practice doe recur;  The facility will annually revie	ure es not	511.2	
					update the emergency preparedness binder.	wand		
					4. how the corrective actic will be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place	ne ur,		
					The facility will review the pol and procedures annually.	icies		
E 0036 SS=F Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §466 §483.73(d), §483. §485.68(d), §485.	5(d), 483.475(d), 483.73(d), 225(d), 485.68(d), 220(d), 486.360(d),						
	Hospice at §418.1 PACE at §460.84 HHAs at §484.102 CAHs at §486.629 485.727, CMHCs	§403.748, ASCs at §416.54, 113, PRTFs at §441.184, , Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at HC/FHQs at §491.12:] (d)						

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Training and testing. The [facility] must

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155003	ì	UILDING	NSTRUCTION	COM	E SURVEY PLETED 2/2022
	ROVIDER OR SUPPLIEF HEALTH CARE CE		STREET ADDRESS, CITY, STATE, ZIP COD 900 PROVIDENT DRIVE WARSAW, IN 46580				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE PROPRIATE	(X5) COMPLETION DATE
	preparedness trai that is based on the in paragraph (a) of assessment at passection, policies at (b) of this section, plan at paragraph training and testing reviewed and updd *[For LTC facilities and testing. The land maintain an estraining and testing the emergency plate of this section, risk (a)(1) of this section at paragraph (b) of communication plate in the emergency plan section. The train must be reviewed annually.  *[For ICF/IIDs at § testing. The ICF/IIIDs at § testing. The ICF/IIDs a	ragraph (a)(1) of this nd procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years.  s at §483.73(d):] (d) Training LTC facility must develop emergency preparedness g program that is based on an set forth in paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least  \$483.475(d):] Training and (D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every					

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	WEDICAKE & WEDIC			ON COMPANION I	OVID NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155003	B. WING		11/02/2022	
	PROVIDER OR SUPPLIER		900 PF	ADDRESS, CITY, STATE, ZIP COD ROVIDENT DRIVE AW, IN 46580		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	dialysis facility muemergency prepared and patient orient on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the community of this section. The orientation progratupdated at every and Based on record review and Preparedness Plan (Plan at least annual 483.73(a). This defoccupants.  Findings include:  Based on records reand Maintenance Da.m., the EEP coverdate was 01/01/20, be found to show the Plan was reviewed year. Based on an increview, the Adminit Director stated the EEP Training and Taupdated within the	and orientation. The set develop and maintain an redness training, testing ation program that is based a plan set forth in paragraph risk assessment at set this section, policies and agraph (b) of this section, cation plan at paragraph (c) he training, testing and m must be evaluated and 2 years. We will an accordance with 42 CFR icient practice could affect all service with the Administrator director on 11/02/22 at 10:01 at page showed the last review no other documentation could be EPP Training and Testing and updated within the last interview during records strator and Maintenance documentation to show the desting Plan was reviewed or last year could not be found.	E 0036	<ol> <li>what corrective action(s be accomplished for those residents found to have been affected by the deficient pract</li> <li>An in-service was completed 11-16-22 and staff signed the training sheet.</li> <li>how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;</li> <li>The facility will continue to complete all staff in-service and training annually.</li> <li>what measures will be printo place and what systemic changes will be made to ensure that the deficient practice does recur;</li> <li>The facility will have continuous staff training about the emerging preparedness.</li> </ol>	ice; on ing the and ut tre s not us all	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155003	B. WI	NG	<del>.</del>	11/02	/2022	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			OVIDENT DRIVE			
MASON	HEALTH CARE CE	NTER			AW, IN 46580			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0037 SS=F Bldg	441.184(d)(1), 48: 483.73(d)(1), 484. 485.68(d)(1), 485. 486.360(d)(1), 49 EP Training Progr §403.748(d)(1), §4 §441.184(d)(1), §4 §483.73(d)(1), §4 §485.68(d)(1), §4 (1), §485.920(d)(1) §491.12(d)(1).  *[For RNCHIs at § Hospitals at §482. HHAs at §484.102 §485.727, OPOs at §491.12:] (1) Training prograll of the following (i) Initial training ir policies and proceexisting staff, indivunder arrangement	416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 83.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d) 1), §486.360(d)(1), 403.748, ASCs at §416.54, 15, ICF/IIDs at §483.475, 2, "Organizations" under at §486.360, RHC/FQHCs			4. how the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;  The management team's annureview of the emergency preparedness plan.	e r, and		

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at least every 2 years.

(ii) Provide emergency preparedness training

(iii) Maintain documentation of all emergency

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155003		A. BUILDING B. WING	COMPLETED 11/02/2022		
	PROVIDER OR SUPPLIER		900 P	ADDRESS, CITY, STATE, ZIP COD ROVIDENT DRIVE SAW, IN 46580	
(X4) ID PREFIX	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	preparedness train (iv) Demonstrate semergency proced (v) If the emergen and procedures an [facility] must condupdated policies at The hospice must (i) Initial training in policies and proceexisting hospice existing hospice existing hospice existent with the (ii) Demonstrate semergency proced (iii) Provide emergency	etaff knowledge of dures. cy preparedness policies re significantly updated, the duct training on the and procedures.  §418.113(d):] (1) Training. do all of the following: n emergency preparedness edures to all new and imployees, and individuals a under arrangement, eir expected roles.  taff knowledge of dures. gency preparedness training	TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE CONFECTION DATE
	emergency preparemployees (included with special emphosis the procedures nearly of the procedures and others.  (v) Maintain docur preparedness train (vi) If the emerger and procedures and procedures are procedures.  *[For PRTFs at §4 program. The PRT following:  (i) Initial training in policies and procedures and procedures.	view and rehearse its redness plan with hospice ling nonemployee staff), asis placed on carrying out ecessary to protect patients mentation of all emergency ning. ncy preparedness policies re significantly updated, the duct training on the and  441.184(d):] (1) Training TF must do all of the a emergency preparedness edures to all new and			
	1 .	viduals providing services			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155003		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022		
		ROVIDER OR SUPPLIEF			900 PR	DDRESS, CITY, STATE, ZIP COD OVIDENT DRIVE W, IN 46580		
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)		ATE	(X5) COMPLETION
	TAG	consistent with the (ii) After initial train preparedness train (iii) Demonstrate is emergency proced (iv) Maintain docu preparedness train (v) If the emergen and procedures and PRTF must condupolicies and procedures and their expected role (ii) Provide emergency procedure) at least every 2 yes (iii) Demonstrate is emergency procedure) at least every 2 yes (iv) Maintain docu (v) If the emerger and procedures	ning, provide emergency ning every 2 years. staff knowledge of dures. mentation of all emergency ning. cy preparedness policies re significantly updated, the act training on the updated edures.  60.84(d):] (1) The PACE do all of the following: n emergency preparedness edures to all new and viduals providing on-site rangement, contractors, volunteers, consistent with es. ency preparedness training ears. staff knowledge of dures, including informing at to do, where to go, and n case of an emergency, mentation of all training, ncy preparedness policies re significantly updated, the act training on the updated edures.  es at §483.73(d):] (1) The LTC facility must do all on emergency preparedness edures to all new and viduals providing services ont, and volunteers,		IAU			DATE

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Facility ID: 000003

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PRINTED: 11/30/2022 FORM APPROVED

ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMP		
		155003	B. WI	NG		11/02	/2022	
NAME OF	PROVIDER OR SUPPLIE	TR			ADDRESS, CITY, STATE, ZIP COD			
					OVIDENT DRIVE			
MASON	HEALTH CARE CE	ENIER		WARSA	AW, IN 46580			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION	
TAG		OR LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
	at least annually.	gency preparedness training						
	1	umentation of all emergency						
	preparedness tra							
		staff knowledge of						
	emergency proce							
	*[For CORFs at §	§485.68(d):](1) Training. The						
	-	Il of the following:						
	(i) Provide initial t	training in emergency						
		licies and procedures to all						
		staff, individuals providing						
		rrangement, and volunteers,						
		neir expected roles.						
	1 ' '	gency preparedness training						
	at least every 2 y	rears. umentation of the training.						
		staff knowledge of						
	l ` ′	edures. All new personnel						
		and assigned specific						
		egarding the CORF's						
	emergency plan	within 2 weeks of their first						
		ining program must include						
		location and use of alarm						
	1 -	nals and firefighting						
	equipment.	onov proporodnosa zalisiaa						
		ency preparedness policies are significantly updated, the						
		duct training on the updated						
	policies and proc							
	*[For CAHs at §4	.85.625(d):] (1) Training						
	1 . •	AH must do all of the						
	following:							
		in emergency preparedness						
		edures, including prompt						
		inguishing of fires,						
	protection, and w	here necessary, evacuation						

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of patients, personnel, and guests, fire prevention, and cooperation with firefighting

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155003	B. W	ING		11/02/	2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			OVIDENT DRIVE		
MASON	HEALTH CARE CE	NTER		WARSAW, IN 46580			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		orities, to all new and					
	1	viduals providing services					
		nt, and volunteers,					
	consistent with their expected roles.  (ii) Provide emergency preparedness training at least every 2 years.  (iii) Maintain documentation of the training.						
	1 ' '	staff knowledge of					
	emergency proced	<u> </u>					
		ncy preparedness policies					
	and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.						
	*[For CMHCs at §	485.920(d):] (1) Training.					
	The CMHC must	provide initial training in					
	emergency prepa	redness policies and					
	procedures to all r	new and existing staff,					
	individuals providi	ng services under					
	arrangement, and	volunteers, consistent with					
	their expected role	es, and maintain					
		the training. The CMHC					
		e staff knowledge of					
		dures. Thereafter, the					
	CMHC must provi	9 9					
		ning at least every 2 years.		227			11/22/222
		view and interview, the facility	E 0	J3 <sup>-</sup> /	1. what corrective action(s)	WIII	11/22/2022
		nnual training for the			be accomplished for those		
		edness Program (EPP). The LTC of the following: (i) Initial			residents found to have been affected by the deficient practi	00:	
	1	or the following: (1) initial cypreparedness policies and					
		ew and existing staff,			The facility will continue all sta training annually. New hires w		
					training annually. New filles w	ııı D <del>C</del>	
	individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR				l trained at the date of fille.		
					2. how other residents havi	na	
					the potential to be affected by		
					same deficient practice will be		
					identified and what corrective		
		deficient practice could affect			action(s) will be taken;		
	1031/3(d) (1). This deficient practice could affect				· '		

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155003	A. BUILDING B. WING	<del></del>	COMPLETED 11/02/2022			
		133003	_		11/02/2022			
NAME OF P	ROVIDER OR SUPPLIER	S.		ADDRESS, CITY, STATE, ZIP COD				
MASON I	HEALTH CARE CE	NTER	WARSAW, IN 46580					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG		L LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
	all residents in the f	acting.		The facility will complete annu				
	Findings include:			staff training.	ai aii			
	Based on records re	view with Maintenance		3. what measures will be p	ut			
	Director on 11/02/2			into place and what systemic				
	documentation of annual EEP staff training and no			changes will be made to ensu	re			
		now staff could demonstrate	1	that the deficient practice does				
	knowledge of the El	PP was available for review.		recur;				
	Based on an interview	ew at the time of records						
	review, the Maintenance Director stated the			All staff training will				
	annual EEP staff training could not found.			occur annually to review				
				emergency preparedness.				
	This finding was reviewed with the Administrator							
		irector during the exit						
	conference.			4. how the corrective action	, ,			
				will be monitored to ensure the				
				deficient practice will not recui	ſ,			
				i.e., what quality assurance	, and			
				program will be put into place;	and			
				-   Management team will review	the			
				policies and procedures of the				
			emergency preparedness plan					
				annually.				
K 0000								
Bldg. 01								
	_	Recertification and State	K 0000	The creation and submission	of			
		ucted by the Indiana		Plan of Correction does not				
	-	th in accordance with 42 CFR		constitute an admission by this				
	483.90(a).			provider of any conclusion set				
	Survey Date: 11/02	1/22		in the statement of deficiencie any violation or regulation. We	· I			
	Survey Date: 11/02/22  Facility Number: 000003			requesting paper compliance.				
				Please see supporting				
	Provider Number:			documentation attached.				
	AIM Number: 1002		1					

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155003	B. Wl	NG		11/02/	/2022
NAME OF P	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					OVIDENT DRIVE		
MASON	HEALTH CARE CE	NTER		WARSA	AW, IN 46580		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION  Code survey, Mason Health		TAG	DEFICIENC!)		DATE
		und not in compliance with					
	Requirements for P	-					
	_	, 42 CFR Subpart 483.90(a),					
		Life Safety from Fire and the 2012 edition of the					
	-	ction Association (NFPA) 101,					
	Life Safety Code (I	Life Safety Code (LSC), Chapter 19, Existing					
	Health Care Occupa	ancies, and 410 IAC 16.2.					
	•	ity was determined to be of ruction and was fully					
	` ` '						
	sprinklered. The original building consists of the 100, 200, 300, and center service hall. An addition was built in 2008 consisting of the 400 hall and						
		e facility has a fire alarm					
		detection in the corridors,					
		orridors and hard wired smoke					
		dent rooms. The building is					
	partially protected b						
		gency generator. The facility					
	has a capacity of 11	5 and had a census of 86 at					
	the time of this surv	/ey.					
	All areas where the	residents have customary					
		ered. The facility had two					
	_	viding facility services					
	_	ge of activity supplies,					
		es and housekeeping supplies					
	which were not spri						
	1						
	Quality Review cor	mpleted on 11/10/22					
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
-	_	d means of egress shall not					
be equipped with a latch or a lock the							
	requires the use of	of a tool or key from the					
		s using one of the following					
	special locking arr	rangements:					

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Facility ID: 000003

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155003	(X2) MUI A. BUI B. WIN	LDING	nstruction 01	(X3) DATE COMPL 11/02/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 900 PROVIDENT DRIVE WARSAW, IN 46580					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  DUSC DEPUTIENTLY DUSC DUSCOMATION	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA PERCENCY.	TE	(X5) COMPLETION	
	REGULATORY OF CLINICAL NEEDS LOCKING Where special loc clinical security ne used, only one loc permitted on each be made for the ra by: remote control locks or keys carri other such reliable staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT: Where special loc safety needs of th the Clinical or Sec are being met. In a electrical locks tha release upon loss building is protect automatic sprinkle space is protected detection system at an attended loc space); and both is systems are arran upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT: Approved, listed de	RECY MUST BE PRECEDED BY FULL RESCRIPTING INFORMATION SOR SECURITY THREAT  Reking arrangements for the edge of the patient are exing device shall be a door and provisions shall apid removal of occupants. I of locks; keying of all ited by staff at all times; or expenses available to the example of the existing arrangements for the experient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised expenses and the locked of by a complete smoke (or is constantly monitored exation within the locked the sprinkler and detection aged to unlock the doors  2.2.5.2, TIA 12-4 SS LOCKING	P		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  DEFICIENCY	TE		
	assemblies servin contents in buildin an approved, supe detection system	permitted on door  g low and ordinary hazard  gs protected throughout by  ervised automatic fire  or an approved, supervised						
J	automatic sprinkle	r system.	I	l				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155003	B. W	NG _		11/02	/2022	
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	R			OVIDENT DRIVE			
MASON	HEALTH CARE CE	NTFR			AW, IN 46580			
1717 (0011		THE CONTRACTOR OF THE CONTRACT		VV/ (1 (O/				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	18.2.2.2.4, 19.2.2							
	ACCESS-CONTR							
	LOCKING ARRAN							
		d Egress Door assemblies						
	installed in accordance with 7.2.1.6.2 shall be permitted.  18.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected							
	throughout by an approved, supervised							
	automatic fire detection system and an							
	approved, supervised automatic sprinkler							
	system.	·						
	18.2.2.2.4, 19.2.2	.2.4						
	Based on observation	on and interview, the facility	K 0	222	1. what corrective action(s)	will	11/16/2022	
	failed to ensure the	means of egress through 3 of			be accomplished for those			
		eadily accessible for residents			residents found to have been			
		iagnosis requiring specialized			affected by the deficient practice;			
	-	Doors within a required means						
	_	be equipped with a latch or			The individ			
	^	ne use of a tool or key from the			codes were placed on the key			
	-	therwise permitted by LSC			pads on the exit doors for 100			
		ocking arrangements shall be			300, and 400 halls. Please see			
	_	ance with 19.2.2.2.5.2. This			attached pictures of corrective			
	_	ould affect over 55 residents in			action.			
	three halls.							
	Eindings in aluda.				2 have ather residents have			
	Findings include:				2. how other residents have	-		
	Based on observativ	on with the Maintenance			the potential to be affected by same deficient practice will be			
		2 between 11:00 a.m. and 1:13			identified and what corrective			
	p.m., the exit doors on 100, 300, and 400 halls were				action(s) will be taken;			
	marked as a facility exit, were magnetically locked,				action(s) will be taken,			
	and could be opened by entering a four-digit code on the access control pads, but the code was not				Other exit doors were checked	d to		
					ensure that the codes were or			
		Based on interview at the time			access control pads. The			
		Maintenance Director agreed			maintenance department will			

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DEPARTMENT OF HEALTH AND HUMA	AN SERVICES	
CENTERS FOR MEDICARE & MEDICAI	D SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155003		ľ í	ILDING	nstruction 01	(X3) DATE : COMPL 11/02/	ETED	
	ROVIDER OR SUPPLIER			900 PR	DDRESS, CITY, STATE, ZIP COD OVIDENT DRIVE W, IN 46580		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	by the access control This finding was rev	e exit doors were not posted of pads.  viewed with the Administrator irector during the exit			check doors weekly for the new week starting 11-16-22. Please see attached audit tool.  3. what measures will be pure into place and what systemic changes will be made to ensure that the deficient practice does recur;  The codes have been placed by the doors and will be monitored weekly for the next 6 weeks by the maintenance department.  4. how the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;  The maintenance department to be using an audit tool to monitored.	e ut e not by d v (s) e , and	
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cookin appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer			the doors.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155003		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/02/2022	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 900 PROVIDENT DRIVE WARSAW, IN 46580				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		TE	(X5) COMPLETION DATE
	* cooking facilities with 30 or fewer p conditions under Cooking facilities NFPA 96 per 9.2 enclosed as haza be open to the cooking facilities NFPA 96 per 9.2 enclosed as haza be open to the cooking facility 19.3.2.5.8 Based on observation failed to ensure staffied to ensure	sin smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not rridor.  18.3.2.5.4, 19.3.2.5.1  5, 9.2.3, TIA 12-2  19. 10. 11. 12. 12. 13. 13. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15	K 032	24	1. what corrective action(s) be accomplished for those residents found to have been affected by the deficient practic. The therapy staff has been trato shut off the breaker when the stove is not in use. A sign has been placed above the stove indicating where the breaker is located. Please see attached picture of breaker location and in-service training on stove.  2. how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  The therapy staff was trained shutting off the breaker to stow when not in use and the location of breaker.  3. what measures will be pinto place and what systemic changes will be made to ensut that the deficient practice does	ice; ined ne s ing the on /e on ut	11/16/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	01	COMPL	ETED
		155003	B. WIN	G		11/02/	/2022
			<del></del>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER						
MASONII		NTED			OVIDENT DRIVE		
IVIASON	HEALTH CARE CE	NIER		WARSA	AW, IN 46580		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on observation	on with the Maintenance			recur;		
	Director on 11/02/2	2 at 12:14 p.m., there was a					
	cooktop in the thera	py gym that was separated			Therapy staff was trained on		
	from the corridor, b	ut staff were unable to			11-16-22 on proper procedure	of	
	deactivate the cookt	top from power. Based on			stove usage in the therapy gyr	n.	
	interview at the time	e of observation, the			Please see attached in-service	e	
		or was asked if staff were able			training tool.		
	to deactivate the cod	oktop and lock the switch.					
	The Maintenance di	rector stated the shut off					
	switch is in the elec-	trical room in a braker box, but			<ol><li>how the corrective action</li></ol>	ı(s)	
	staff did not have ac	ccess to the braker box.			will be monitored to ensure the	÷	
					deficient practice will not recur		
The finding was reviewed with Maintenance Director and Adminstrator during the exit				i.e., what quality assurance			
				program will be put into place;	and		
	conference.						
					The maintenance staff will che		
	3.1-19(b)				stove weekly for the next 6 we	eks.	
					-		
14 0007							
K 0927	NFPA 101	- cu: 0 :: 1					
SS=E		Transfilling Cylinders					
Bldg. 01		Transfilling Cylinders					
		gen from one cylinder to					
		rdance with CGA P-2.5,					
		n Pressure Gaseous					
		Respiration. Transfilling of					
		cylinder to another is					
		nt care rooms. Transfilling					
		ontainers or to portable					
		) psi comply with conditions NFPA 99). Transfilling to					
	,	ainers or to portable					
	containers under 5						
		1.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 99	,					
		on and interview, the facility	K 092	27	what corrective action(s)	will	11/04/2022
		1 oxygen storage room where	IX 092	<i>- 1</i>	be accomplished for those	**111	11/04/2022
oxygen transferring takes place, was provided					residents found to have been	ļ	
		ing mechanical ventilation.			affected by the deficient practi	ce	
		ion, 11.5.2.3.1 (2) requires			and delicition by the delicition practi		
		, (2) requires				Ų	

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Facility ID: 000003

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER  155003	A. BUILDING 01  B. WING		COMPLETED 11/02/2022			
NAME OF PROVIDER OR SUPPLIER  MASON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 900 PROVIDENT DRIVE WARSAW, IN 46580					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE				
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Z1Q21

Facility ID: 000003

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OND NO. 0500 05									
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED				
		155003	B. WING		<u> </u>	11/02/2022			
					_				
NAME OF PROVIDER OR SUPPLIER				STREET A	EET ADDRESS, CITY, STATE, ZIP COD				
				900 PROVIDENT DRIVE					
MASON HEALTH CARE CENTER				WARSAW. IN 46580					
				,					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE		
					monitor weekly for the next 6				
					weeks.				

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