

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/10/2023	
NAME OF PROVIDER OR SUPPLIER MASON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DRIVE WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) of Complaint Number IN00415890 conducted on 08/23/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Complaint Number IN00415890 - corrected.</p> <p>Survey Date: 10/10/23</p> <p>Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600</p> <p>At this PSR Complaint survey, Mason Health Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2.</p> <p>This one-story facility was determined to be of Type V (000) construction 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 therapy center. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The building is partially protected by a 50 kW Natural Gas-powered emergency generator. The facility has a capacity of 115 and had a census of 81 at the time of this survey.</p> <p>All areas where the residents have customary</p>			{K 000}			

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

TITLE

(X6) DATE

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.

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{K 000}	Continued From page 1 access were sprinklered. The facility had two detached sheds providing facility services including the storage of activity supplies, maintenance supplies and housekeeping supplies which were not sprinklered. Quality Review completed on 10/12/23	{K 000}			