STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155003	A. BUILDING 00 B. WING	12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MASON HEALTH CARE CENTER	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00422660, IN00423083 and IN00423682. Complaint IN00422660 - No deficiencies related to the allegations are cited. Complaint IN00423083 - Federal/state deficiencies related to the allegations are cited at F610. Complaint IN00423682 - Federal/state deficiencies related to the allegations are cited at F755. Survey dates: December 27 & 28, 2023 Facility number: 000003 Provider number: 155003 AIM number: 100290600 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 6 Medicaid: 51 Other: 14 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/2/24.	F 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. We ask that you consider paper compliance for this survey.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rukiya Brooks | HFA | 01/12/2024

Any defiencystatement 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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	the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure through investigations were completed for misappropriation of resident property for 2 of 2 allegations of misappropriation of resident property reviewed. (Residents B & F) Findings include: 1. A State Reportable Form was provided on 12/27/2023 at 12:10 P.M. Under the Brief Description of Incident, the following was documented: 11/30/2023 Resident B reported she was missing $27.00 from her coin purse. The resident noticed the money missing on 11/29/2023 while out at dialysis. Resident B was unable to identify when she last saw the money. The HFA (Health Facility Administrator) initiated an internal investigation. Immediate action taken documented was a lock box provided. Follow up documentation included: HFA completed the investigation. Investigation concluded the resident noticed the $27.00 missing on 11/28/2023. HFA reviewed the camera and was unable to	F 0610	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Corrective action cannot be taken for Resident F and Resident B as the alleged deficiency occurred in the past. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. what measures will be put into place and what systemic changes will be made to ensure	01/30/2024

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	determine if the money was stolen. A Misappropriation of Resident Funds or Property Form indicted the following: Date/Time of Incident/Discovery: 11/28/2023. Description of Misappropriation: missing money $27.00. Staff member(s) who discovered/reported misappropriation: unit manager reported money missing to the Administrator. Description of Resident's initial interview: Resident noticed the money was missing on her way back from dialysis. She had asked the driver to pick up food and when she looked in her coin purse, she noticed it was missing. Investigation initiated, including interview of staff - response was blank. When was item last seen- unknown- resident unable to recall. Describe any concern with validity of whether item was present as reported: N/A. Was family called to determine is resident had item in their possession: daughter notified but unable to tell when the money was last seen. If the item was money, did resident have it in their possession? response was blank. Other residents interviewed for potential lost items: resident's roommate. Resident offered lock box to secure items (if appropriate): Yes. Local authorities contacted (as appropriate): resident declined. On 12/27/2023 at 12:30 P.M., the HFA provided her investigation of the incident as follows: - A typed sheet indicted the following: On 11/29/2023, the HFA was informed of Resident B's missing money. The HFA spoke to the resident regarding her missing money. The resident reported $27 missing (1-$20, 1-$5, and 2-$1). Resident B explained that she noticed the money missing while on the bus coming back from dialysis on 11/25/2023. She asked the driver to make a stop because she wanted to buy food. At that time, she went to reach for her coin purse		that the deficient practice does not recur; All staff including the HFA will be in-serviced on the “Freedom from Abuse, Neglect, Exploitation, and Misappropriation Policy” by the Clinical Educator 1-30-24. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Regional Director of Operations/designee will review misappropriation investigations to ensure thorough investigation. This will occur weekly for 8 weeks then bi-weekly for 8 weeks then monthly for 2 months. Ongoing monitoring will occur monthly thru QA until 100% compliance is achieved.	

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	hanging on her wheelchair and noticed it was open with no money in it. The HFA asked if she believed the money could've fallen out and she stated no. Resident B was unable to report when she last saw the $27.00. She explained she kept her money in a coin purse that she either kept around her neck or on her wheelchair. The HFA informed the resident she would initiate an investigation. Resident B declined police involvement and asked that the HFA review the cameras. The HFA confirmed she would review the cameras. Resident B was provided with a lock box. - On 12/1/2023, The HFA contacted Resident B's daughter regarding the missing money. The daughter was unable to identify when the money was last seen. She explained that her mother kept her money in her coin purse. - On 12/1/2023, the HFA reviewed the camera for 11/25/23 as the time is one of Resident B's dialysis days. The HFA observed Resident B leaving for dialysis at approximately 11:45 A.M. - CNA's 11, 13 and QMA 12 were working on Resident B's hall that day. - On 12/1/2023, the HFA spoke to QMA 12, who was the QMA on 11/25/2023. QMA 12 indicated she did not see Resident's B coin purse, but she did observe a plastic cup with coins in it on the resident's bedside table. - On 12/1/2023, the HFA spoke to Employee 14, the driver who transported Resident B to dialysis on 11/26/2023. Employee 14 indicated on the way to the facility, the resident asked him to stop so she could get food. The resident indicated she had money in her coin purse and began to reach for it. Employee 14 stated the resident looked at her coin purse and noticed there was no money in the coin purse. Employee 14 indicated he believed the money could have fallen out of the coin purse. - On 12/6/2023, the HFA spoke to Resident B's roommate and asked if she had noticed anybody			

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	coming into and going through the room while Resident B wasn't present. The roommate indicated no. The roommate indicated that a couple days before her money went missing, Resident B attempted to buy a pop out out of the vending machine. The roommate indicated she last saw the money on the table then, as Resident B was counting it. During an interview, on 12/28/2023, at 11:29 A.M., the HFA indicated she did not get hold of all the staff who were working to interview them, and had not interviewed any other residents regarding any missing money. 2. A State Reportable Form was provided on 12/27/2023 at 12:10 P.M. Under the Brief Description of Incident the following was documented: 11/13/2023 Resident F reported he was missing $40.00, 2- $20.00 bills from his room. Immediate action taken: 11/13/2023 the HFA was notified and an investigation initiated. Resident F was given a lock box to keep his wallet in. Follow up documentation included: 11/17/2023 Investigation completed. The HFA reviewed cameras and interviewed staff and was unable to determine if the money was stolen. The HFA updated the resident with findings. The resident stated "then he probably lost the money". A Misappropriation of Resident Funds or Property Form indicted the following: Date/Time of Incident/Discovery: 11/13/2023. Description of Misappropriation: $40.00 (two $20 bills). Staff member(s) who discovered/reported misappropriation: The resident reported missing money to therapy staff on 11/13/20023. Description of Resident's initial interview: The resident stated that he had left the money in his wallet on the top drawer of his bedside table.			

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	There was a total of $126.00 initially. He stated $40.00 was missing, which left him with $86.00. Investigation initiated including interview of staff: Yes. When was item last seen: 11/12/2023. Describe any concerns with validity of whether item was present as reported: N/A. The HFA reviewed cameras and saw two visitors, a man an a woman, however the resident refused to provide contact info. Other residents interviewed for potential lost items: No. Resident offered lock box to secure items: Yes. Resolution discussed with resident/resident representative: Yes. The HFA was unable to confirm money was stolen. On 12/27/2023 at 12:30 P.M., the HFA provided her investigation of the incident as follows: - A typed sheet indicted the following: On 11/14/2023 the HFA interviewed Resident F regarding missing money. The resident stated that the last time he saw the money was on the afternoon of 11/12/2023. He observed the money missing late afternoon/early evening. The HFA informed the resident she would review the camera and complete interviews. The resident did confirm he had friends visit on Sunday, but stated, "they wouldn't do that." - On 11/16/2023, the HFA reviewed the camera from 12:00 P.M. to 6:30 P.M. on 11/12/2023. The HFA did not observe the resident leaving his room during that time frame. The HFA did observe the resident receive 2 visitors, a man and a woman. The HFA observed a nurse and aides in an out of the resident's room to answer his call light and provide meal trays. The HFA observed LPN 15 enter the residents' room. The HFA asked LPN 15 if she had to go in Resident F's drawers and she stated No. The HFA asked LPN 15 if she observed or was offered any money and she stated No. - On 11/17/2023, The HFA interviewed CNA 16,			

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	who was observed on the camera going into the residents' room on 11/12/2023. CNA 16 indicated the times she went in the resident's room she had emptied his urinal, provided ice water, and transferred him with another aide from his wheelchair to the bed. CNA 16 indicated she did not observe any money. - On 11/17/2023, the HFA spoke to Housekeeper 17, who was observed on camera entering the resident's room on 11/12/2023. The housekeeper indicated she did not see any money, nor did she open any drawers in the resident's room. The HFA asked if the resident offered her any money and she indicated no. - On 11/17/2023, the HFA updated the resident regarding the missing money. The HFA indicated she had spoken to staff and reviewed the camera and was unable to determine if the money was stolen. The HFA indicated she observed 2 visitors on the camera and asked if she could have their contact information to speak to them. The resident indicated he did not believe they would have taken the money and declined to provide contact information. The HFA indicated she could not confirm the money was stolen. The resident was receptive of the findings and declined police involvement. The resident agreed to continue to use a lock box. During an interview on 12/28/2023 at 11:29 A.M., the HFA indicated she did not get hold of the other staff who were working for interviews, and had not interviewed any other residents regarding any missing money. On 12/28/2023 at 11:40 A.M., the Administrator provided the policy titled,"Freedom from Abuse, Neglect, Exploitation and Misappropriation of Property", dated 10/17/2022, and indicated the policy was the one currently used by the facility.			

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	The policy indicated... The resident has the right to be free from abuse, neglect, misappropriation of resident property... Misappropriation of Resident Property - means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent...Resident's property includes all resident's possessions, regardless of their apparent value to others...Examples of resident property includes...money... The facility should fully investigate all allegations of abuse, neglect, exploitation, and misappropriation of resident property.... This citation relates to Complaint IN00423083. 3.1-28(d)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to have a process of accountability for medications awaiting final disposition for 4 of 8 residents whose medications were reviewed for disposition. (Resident H, Resident J, Resident K, and Resident L). Findings include: On 12/28/2023 at 10:40 A.M., an observation of the medication storage room on the front hall with the Director of Nursing (DON) was completed. A yellow bin identified as the medication disposition bin by the DON contained packets of medication that were not labeled for disposition. The following single dose medication packets were observed in the yellow bin without a disposition reason: a. A packet with a dexamethasone pill, dated 12/8/2023, a packet with a sodium chloride pill, dated 12/22/2023, and a packet with a sucralfate pill, dated 12/17/2023, all labeled for Resident H. b. Packets with magnesium oxide pills, dated 11/3/2023, 12/4/2023, and 12/5/2023, all labeled for	F 0755	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Corrective action cannot be taken as the alleged deficiency occurred in the past. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All medication storage areas were audited and	01/30/2024

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	Resident J. c. A packet with an omeprazole pill, dated 12/22/2023, labeled for Resident K. d. A packet with a furosemide pill, dated 9/20/2023, labeled for Resident L e. A medicine cup with five individually wrapped propranolol 10 mg (milligrams) tablets with no resident identifiers was in the disposition bin. During an interview, on 12/28/2023 at 11:10 A.M., the DON indicated she couldn't identify why the five individually wrapped propranolol tablets or the single dose medication packets for Resident H, Resident J, Resident K, and Resident L needed to be dispositioned. The DON indicated the single dose medication packets weren't labeled with a disposition reason, but the medication packets should have been labeled with a disposition reason. During an interview on 12/28/2023 at 2:05 P.M., LPN 9 indicated a disposition reason should be written on the single dose medication packet if the medication was not given before it was placed into the medication disposition bin. During an interview on 12/28/2023 at 2:15 P.M., LPN 10 indicated the process of not giving a medication to a resident included labeling the single dose medication packet with a reason why the medication was not given before placing the medication into the medication disposition bin. On 12/28/2023 at 11:38 A.M., the DON provided a policy titled, "Drug Disposition", dated 2/2022, and indicated the policy was the one currently used by the facility. The policy indicated, "...6.		medications that were no longer in use destroyed or returned to pharmacy as appropriate. Nursing staff will be in-serviced on the facility policy for drug disposition. A new procedure will be implemented to ensure drug disposition forms are completed and medications are destroyed or sent back to pharmacy in a timely manner. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The DON will monitor unused medications to ensure timely documentation and return of medications. This will occur weekly for 4 weeks, then biweekly for 8 weeks then monthly for 3 months. It will be followed through Quality Assurance monthly until 100% compliance is achieved.	

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	The drug disposition record must contain, as a minimum, the following: (and must be scanned into the resident's record) ...i. reason for destruction...." This citation relates to Complaint IN00423682. 3.1-25(r)			