

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

PRINTED: 07/02/2025

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155003		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/17/2025	
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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00461321.</p> <p>Complaint IN00461321 - Federal/state deficiencies related to the allegations are cited at F693.</p> <p>Survey dates: June 16 & 17, 2025</p> <p>Facility number: 000003 Provider number: 155003 AIM number: 100290600</p> <p>Census Bed Type: SNF/NF: 68 Total: 68</p> <p>Census Payor Type: Medicare: 6 Medicaid: 44 Other: 18 Total: 68</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on 6/23/2025</p>			F 0000	<p>We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is provided as evidence of the facilities desire to comply with regulations and continue to provide quality care. Please accept this Plan of Correction as our credible allegation of compliance.</p>		
F 0693 SS=D Bldg. 00	<p>483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills</p> <p>Based on record review and interview, the facility failed to ensure appropriate feeding tube care was provided regarding water flushes before and after medication administration and insertion site care for 1 of 3 residents reviewed for tube feeding. (Resident F)</p>			F 0693	<p>Resident F no longer resides at the facility. The medical record for resident F was reviewed and no negative affects were noted related to lack of physician order. Interview was completed with the nursing staff who provided care for</p>		07/04/2025

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

TITLE

(X6) DATE

Jaime Sevier

RN, RDQA

06/29/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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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	<p>Finding includes:</p> <p>A complaint to the Indiana Department of Health (IDOH) was received on 6/11/2025 at 9:48 A.M. The complaint included, but was not limited to: "...cleaning had not been performed around the feeding tube and only a gauze pad had been placed...."</p> <p>A closed record review for Resident F was completed on 6/16/2025 at 10:48 A.M. Diagnoses included, but were not limited to: cerebral infarction (stroke), dysphagia (difficulty swallowing), severe protein-calorie malnutrition and adult failure to thrive.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 4/7/2025, indicated Resident F was cognitively intact and received artificial nutrition and hydration via a feeding tube.</p> <p>A Care Plan, initiated on 4/24/2025, indicated Resident F had a gastrostomy tube (a tube surgically inserted through the abdominal wall directly into the stomach) related to dysphagia and cerebral vascular infarction. Interventions included, but were not limited to: gastrostomy site care was to have been followed and Resident F was to have received water flushes as ordered.</p> <p>A review of Physician Orders, for April 2025, indicated Resident F had no orders for water flushes for medication administration through the feeding tube and had no orders for the feeding tube insertion site care. There was no documentation regarding any medication water flushes before and/or after medication administration and no insertion site dressing changes for Resident F.</p>				<p>this resident. The residents enteral tube was flushed and received site care per individualized plan of care. All other residents residing in the facility that have enteral tubes have a potential to be affected by this deficient practice. Physicians orders for other residents with enteral orders have been reviewed. All appropriate orders are in place per policy and procedure. The policy and procedure for Flushing a Feeding Tube has been reviewed with no changes in policy indicated. The facility nursing staff has been reinserviced by the Director of Nursing regarding the facility policy and procedure for Flushing a Feeding Tube. The DON and/or designee will randomly audit physician's orders for enteral care weekly for four weeks, then every other week for four weeks, then monthly thereafter. The audit will be documented on the Enteral Order review form. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Enteral Order review to ascertain continued compliance at least biannually The DON report of monitoring will be forwarded to the Administrator for monthly QA</p>		

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	<p>During an interview, on 6/17/2025 at 10:27 A.M., RN 2 indicated residents should have orders for flushes for medication administration and insertion site care of the feeding tube.</p> <p>A policy was provided by the Executive Director, on 6/17/2025 at 11:36 A.M. The policy titled, "Flushing a Feeding Tube", indicated, " ...It is the policy of this facility to ensure that staff providing care and services to the resident via a feeding tube are aware of, competent in and utilize facility protocols regarding feeding nutrition and care. Feeding tube care and services will be provided in accordance with resident needs and professional standards of practice ...Policy Explanation and Compliance Guidelines:...10...flush the tube utilizing 60 mL [milliliters] catheter tip syringe using the prescribed amount of water every four [4] hours, before and after feedings and medications or as directed by the physician"</p> <p>A policy was provided by the Executive Director, on 6/17/2025 at 11:36 A.M. The policy titled, "Gastronomy Site Care, indicated, " ...It is the policy of this facility to perform gastronomy site care daily, prn [as needed], or per physician order and per current standards of practice ...Policy Explanation and Compliance Guidelines: 1. Verify there is a physician order for gastronomy site care "</p> <p>This citation relates to Complaint IN00461321.</p> <p>3.1-44(a)(2)</p>				review and the plan of action will be adjusted accordingly.		