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	09/22/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00416862 and IN00417481. Complaint IN00416862 - No deficiencies related to the allegations are cited. Complaint IN00417481 - Deficiencies related to the allegations are cited at F550, F677, and F725. Survey dates: September 18, 19, 20, 21 and 22, 2023. Facility number: 000003 Provider number: 155003 AIM number: 100290600 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 6 Medicaid: 54 Other: 19 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 29, 2023.	F 0000	The creation and submission of Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or set of any violation or regulation. Mason is requesting paper compliance.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

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

Rukiya Brooks | Administrator | 10/13/2023

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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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record	F 0550	1 Corrective action cannot be	10/31/2023

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	review the facility failed to ensure dignity was maintained during the dining experience for 3 of 8 residents in the assisted dining room (Resident 27, Resident 28, and Resident 31). Findings include: During an observation on 9/19/23 at 8:48 AM, eight residents were seated in the assisted dining room, with meals placed in front of them. Qualified Medication Aide (QMA) 5 was the only staff member in the room. QMA 5 stood next to, and leaned over, Resident 27 and picked up a cup she was holding and assisted her to drink. QMA 5 then picked up silverware belonging to Resident 28 and assisted her to take a bite of food. QMA 5 walked across the room to Resident 31, stood next to her, leaned over her, picked up her silverware and assisted her to take a bite of food. Resident 27's record was reviewed on 9/22/23 at 10:14 AM. Diagnoses included unspecified dementia, moderate, with anxiety, type 2 diabetes mellitus without complications, and cognitive communication deficit. A review of Resident 27's current annual Minimum Data Set (MDS) dated 8/15/23, indicated her Basic Interview for Mental Status (BIMS) score was 7 (cognitively impaired). The MDS indicated Resident 27 received extensive assistance with eating. Resident 28's record was reviewed on 9/22/23 at 9:56 AM. Diagnoses included cerebral infarction, metabolic encephalopathy, and hypertension. A review of Resident 28's current admission Minimum Data Set (MDS) dated 8/18/23, indicated her Basic Interview for Mental Status (BIMS)		taken for 27,28 and 31 as the alleged deficiency occurred in the past. 2 All residents needing assistance with eating in the dining room have the potential to be affected by the alleged deficiency. 3 Nursing staff will be in serviced on proper procedure for assisting residents how need help eating. DON/designee will monitor the assisted dining room 3x weekly for 8 weeks then weekly for 8 weeks then monthly for 8 weeks to ensure that residents rights are maintained per policy and procedure. This will be monitored thru QA quarterly until 100% compliance is achieved.	

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	score was 3 (cognitively impaired). The MDS indicated Resident 28 received extensive assistance with eating. Resident 31's record was reviewed on 9/22/23 at 10:14 AM. Diagnoses included unspecified dementia, severe, with mood disturbance, major depressive disorder, and anxiety disorder, unspecified. A review of Resident 31's current quarterly Minimum Data Set (MDS) dated 8/14/23, indicated a Basic Interview for Mental Status test was not conducted because Resident 31 was rarely or never understood. The MDS indicated Resident 31 received extensive assistance with eating. In an interview on 9/19/23 at 8:53 AM, QMA 5 indicated anywhere from 1 to 3 employees assisted residents with meals in the dining room, depending on the day's staffing situation. She had to go table to table if she was in the dining room by herself. During an interview on 9/19/23 at 2:58 PM, the Director of Nursing (DON) indicated staff should be seated when assisting a resident with dining tasks. A current, undated facility policy titled "Procedure #58: Feeding," provided by the Infection Preventionist on 9/19/23 at 2:56 PM, indicated staff should be seated at eye level with the resident when feeding. This Federal Tag relates to Complaint IN00417481. 3.1-3(t)			

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F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review the facility failed to ensure privacy for 3 of	F 0583	1 Corrective action for residents 17, 63 and 135 cannot be taken	10/31/2023

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	24 residents reviewed during random observations. (Resident 17, Resident 63, and Resident 135) Findings include: 1. During an observation on 9/19/23 at 8:33 AM, the 100 hall a computer screen placed on top of the medication cart was visible with Resident 135's name, picture, medication list and other personal information visible. No staff member was in attendance of the cart. Resident 135's record was reviewed on 9/22/23 at 12:37 PM. Diagnoses included spinal stenosis, chronic obstructive pulmonary disease, unspecified, and dysphagia. A review of Resident 135's current admission Minimum Data Set (MDS) dated 9/5/23 indicated her Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). During an interview on 9/19/23 at 3:03 PM, the Director of Nursing indicated computer screens should be closed when not directly attended to ensure privacy. 2. During an observation on 9/20/23 at 12:06 PM the 100 hall a computer screen placed on top of the medication cart was visible with Resident 17's name, picture, medication list and other personal information visible. No staff member was in attendance of the cart. Resident 17's record was reviewed on 9/21/23 at 9:38 AM. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus with diabetic chronic kidney disease, and peripheral		as the alleged deficiency occurred in the past. 2 All residents have the potential to be affected by the alleged deficiency. 3 All staff will be in-serviced on Confidentiality and the need for knocking on doors before entering a room and protecting personal resident information. 4 HFA/designee will observe staff practices for entering a resident's room and maintaining privacy and confidentiality of resident information 3x weekly for 8 weeks then weekly for 8 weeks then monthly for 8 weeks. This will be monitored thru QA quarterly until 100% compliance is achieved.	

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	vascular disease. A review of Resident 17's current Significant Change in Status Minimum Data Set (MDS) dated 8/2/23 indicated her Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). In an interview on 9/19/23 at 12:10 PM, LPN 6 indicated she left the computer screen open because she was going to administer insulin and anticipated returning to the cart very quickly. She indicated Resident 17 wanted to talk, so she was in the room longer than anticipated. She indicated she should have closed the computer before going into the room. 3. During an interview on 9/18/23 at 2:15 PM with Resident 63, in her room, Physical Therapy Assistant (PTA) 8 opened the door, walked in the room, and started talking to Resident 63. PTA 8 did not knock on the door or ask permission to come in before entering the room. Resident 63 indicated staff frequently came into the room without knocking or asking permission to come in. Resident 63's record was reviewed on 9/21/23 at 9:31 AM. Diagnoses included central cord syndrome at C3 level of spinal cord, major depressive disorder, recurrent, and essential hypertension. A review of Resident 63's current quarterly Minimum Data Set (MDS) dated 9/7/23 indicated her Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). In an interview on 9/21/23 at 9:52 AM, the Administrator indicated staff should knock on the door, wait for a response, and ask permission to enter before walking into a resident's room.			

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	A current policy titled Confidentiality, last revised 3/18 provided by the administrator on 9/19/23 at 2:41 PM indicated personal privacy included visits, and confidentiality was defined as safeguarding the content of information from unauthorized disclosure. The policy indicated staff should respect the resident's right to secure and confidential medical records. A current, undated facility policy titled "Procedure #1: Initial Steps," provided by the Director of Nursing on 9/21/23 at 10:19 AM, indicated staff should knock and identify themselves before entering the resident's room, and wait for permission to enter. 3-1(p)(5)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where			

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	state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 observation, interview, and record review the facility failed to ensure an allegation of abuse was reported to the State Agency and investigated for 2 of 24 residents reviewed for abuse (Resident 9, and Resident 11). Findings include: During an observation on 9/18/23 at 11:50 AM in the dining room, Resident 9 was observed holding a two handled, lidded cup. Resident 11 grabbed the cup and tried to pull it away. Each resident held a handle of the cup and pulled it back and forth. Resident 11 grabbed Resident 9's fingers and tried to pry her fingers from the cup. Resident 9 began screaming when Resident 11 grabbed her fingers. Four staff members came in the room, including the Director of Nursing, who assisted in separating the residents. Resident 9's record was reviewed on 9/22/23 at 12:07 PM. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease, and anemia. Resident 11's record was reviewed on 9/21/23 at 1:16 PM. Diagnoses included type 2 diabetes mellitus without complications, hypertension, and	F 0609	1 The incident between resident 9 and 11 was reported to ISDH on the gateway portal 9/22/23. 2 All residents have the potential to be affected by the alleged deficiency. 3 All staff including the Executive Director and Director of Nursing will be in serviced on the facility policy for Freedom of Abuse, Neglect, Exploitation and Misappropriation of Property. 4 Regional Director of Operations/designee will review all resident to resident altercations for possible ISDH reporting. 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.	10/31/2023

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	cognitive communication deficit. In an interview on 9/18/23 at 3:30 PM, the Administrator indicated she was aware of the incident that had occurred in the dining room and the situation was being handled. In an interview on 9/21/23 at 11:45 AM, the Director of Nursing (DON) indicated she heard screaming, saw the residents pulling the cup back and forth and immediately assisted in separating the residents. She indicated she did not witness contact between the residents. The DON was notified contact was witnessed by the surveyor. As of 9/22/23 at 1:00 PM, the Indiana Department of Health had not received a report of the incident from the facility. In an interview on 9/22/23 at 1:49 PM, the Administrator indicated upon notification of an abuse allegation she would report it to the state and begin investigation. The DON indicated normally she would report the incident immediately, but she was busy with the annual survey and did not get a chance to do it. A current policy titled "Freedom from Abuse, Neglect, Exploitation, and Misappropriation of Property," dated 10/17/22 and provided by the Administrator on 9/18/23 at 2:12 PM, indicated an alleged violation was a situation or occurrence that is observed by staff, resident, relative, visitor or another healthcare provider or others that had not been investigated and if verified could be noncompliance with federal requirements related to abuse. A resident-to-resident altercation should be reviewed as a potential situation of abuse. The facility was responsible for reporting allegations/occurrences including resident to			

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	resident altercations. 3.1-28(c)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to respond to a request with positioning and personal care for 1 of 7 residents reviewed for ADLs. (Resident 134) Findings include: On 9/18/23 at 3:47 PM, Resident 134 was observed lying in bed wearing a pink shirt with long sleeves. Resident 134's record was reviewed on 9/20/23 at 9:07 AM. Diagnoses included right lower leg fracture, torn cartilage of the right knee, emphysema and urinary tract infection. Resident 134 was admitted to the facility on 9/12/23. Resident 134's most recent discharge Minimum Data Set (MDS) dated 8/1/23 indicated their Basic Interview for Mental Status (BIMS) score was 15 (no cognitive deficit). The MDS indicated the resident required extensive assistance with bed mobility, personal hygiene and dressing. The MDS indicated the resident required supervision with eating. Resident 134's current care plan for Activities of Daily Living (ADLs) dated 9/13/23 with a goal date of 12/12/23 indicated the resident required	F 0677	1 Resident 134 was repositioned when HFA became aware of residents' needs. 2 All residents have the potential to be affected by the alleged deficiency. 3 Nursing staff will be In serviced on AM and PM resident care and proper positioning of a resident when eating in their bed. 4 DON/designee will monitor resident care 3 times per week for 8 weeks then weekly for 8 weeks then monthly for 2 months. Ongoing monitoring will occur monthly thru QA until 100% compliance is achieved.	10/31/2023

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	the assistance of 1 staff member for bed mobility and dressing. The resident's care plan indicated the resident required supervision for eating. On 9/20/23 at 9:04 AM, Resident 134 was observed wearing a pink shirt with long sleeves. The resident indicated she had worn the same shirt for a couple of days. She did not prefer to wear the same clothing more than one day. On 9/20/23 at 9:38 AM, Resident 134 was observed lying in bed. The resident's bed was elevated at approximately 90 degrees. She was slumped down in the bed. Resident 134 was eating while her chin was at the same level as the bedside table. She indicated she needed assistance to move up in the bed and activated the call light system. On 9/20/23 at 10:01 AM, Resident 134's call light was observed to be on. The resident remained slumped in the bed and her meal tray was on the bedside table. On 9/20/23 at 10:05 AM, Resident 134's call light was observed to be off. An unknown staff member was overheard telling Resident 134 that they would be right back. The resident's meal tray was no longer on the bedside table. She remained slumped down in the bed. On 9/20/23 at 10:15 AM, three staff members were observed at the nurse station. The Administrator and 1 staff member entered Resident 134's room. In an interview on 9/20/23 at 11:32 AM the Administrator indicated they were unaware of lack of nursing staff present on the hall, and Resident 134 had been waiting for assistance from 9:38 a.m. to 10:15 a.m.			

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	In an interview on 9/21/23 at 10:24 AM the Director of Nursing (DON) indicated residents should be provided with personal care every morning and every evening. Morning care should include getting dressed for the day and evening care should include undressing and assisted into a gown or other sleepwear. A current facility policy, dated 6/2021, and provided by the DON, indicated personal hygiene would be provided in the morning and before bed. Personal hygiene included dressing and undressing. This Federal Tag relates to Complaint IN00417481. 3.1-38(a)(3)			
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Based on observation, interview and record review, the facility failed to develop and implement preventative foot care interventions to prevent toenail injury and infection for 1 or 1 residents reviewed for foot care (Resident 19).	F 0687	1 Resident # 19 was seen by the in-house Podiatrist with no concerns noted. His care plans have been reviewed and updated. 2 All diabetic residents have had a foot assessment completed and	10/31/2023

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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
	Findings include: On 9/19/23 at 11:45 A.M., Resident 19's record was reviewed. Diagnoses included diabetes with diabetic peripheral angiopathy (narrowing of arteries), peripheral vascular disease, and long term use of insulin. An annual MDS (Minimum Data Set) assessment, dated 8/8/23, indicated the resident had no cognitive impairment. He was dependent on 2 staff members for bathing and had no foot issues were observed at the time of assessment. Care plans were as follows: 8/11/21: At risk for blood sugars to fluctuate. Interventions included: report and observe for changes in skin and sensation. 7/12/23: At risk for developing pressure ulcers related to impaired mobility and disease process. Interventions included: observe resident's skin weekly. 8/24/23: The resident was prescribed an antibiotic. Interventions included: therapeutic goals for the medication was to resolve his toenail infection. The resident's current care plans did not indicate the resident's history of toe infections which led to amputation of all toes on his left foot. There was no care plan developed to provide preventative care to avoid foot complications related to insulin dependent diabetes, peripheral vascular disease and history of partial foot amputation due to podiatric complications for Resident 19. A physician order, dated 8/24/23, indicated to apply Bacitracin (antibiotic) ointment to the right great toe topically everyday for infection; cleanse		referrals to Podiatry made as needed. 3 All residents wanting to receive in-house ancillary services have had a new consent signed to reflect new provider. A communication tool has been developed to alert Social Services when ancillary services are needed for a resident. A care plan to avoid foot complications for diabetic residents has been initiated for all insulin dependent diabetics. 4 DON/designee will monitor insulin dependent residents to ensure regular podiatry visits are scheduled per their request with ancillary consent forms signed. This will occur monthly for 6 months then monitored thru QA quarterly until 100% compliance is achieved. New admissions will be monitored for care plans related to foot care. This will occur weekly for 8 weeks then biweekly for 8 weeks then monthly for 2 months. Ongoing monitoring will occur monthly thru QA until 100% compliance is achieved.	

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	and apply a dry dressing. The resident had been prescribed and received Keflex (antibiotic) 500 mg (milligrams) by mouth 3 times per day for 7 days for toenail infection from 8/23-8/30/23. Weekly skin observations were as follows: 8/30/23 at 12:25 p.m., Resident 19's toenails were observed to be ingrown and a referral was needed for podiatry services. 9/6/23 at 12:10 a.m., indicated the resident's toenails were hard but weren't in need of being trimmed. 9/13/23 at 3:32 a.m., indicated Resident 19's toenails were not in need of being trimmed. There was no assessment of the nails completed in the observation. On 9/19/23 at 12:13 P.M., Resident 19 was observed lying in bed with both feet lying out from under his sheet. The left foot had a well healed scar across the top of the foot where all his toes had been amputated. The right foot had a bandaid placed on the outer side of his right great toe. The right great toenail was very thick and extended approximately 1 to 1.5 inches about the toe and came to a point. Resident 19 indicated a couple weeks ago, he had noticed blood and drainage on the inner side of his right great toe and toenail. He reported it to the nurses and was worried about the right great toe because he was a diabetic and had lost the toes on his left foot due to an infection which he was "not going to let happen again"! He indicated he was on antibiotics for awhile which had helped, but then the blood and drainage began on the outer side of the right great toe. He indicated he had requested to be seen by the podiatrist to have the toe looked at and his toenails cut and was finally going to see one on this coming Friday.			

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	On 9/21/23 at 9:43 A.M., the wound nurse was observed to do the treatment to Resident 19's right great toe. The right great toe came to a point approximately 1-1.5 inches above the toe. The inner side of the great toe, where the toenail was adjacent to, appeared moist/white/yellow in color. The outer great toe, where the toenail was adjacent to, had red/brown drainage on side of toe with maceration around area of drainage. The 4th right foot toenail was long and thick and all other toes were very dry with thick skin. On 9/20/23 at 1:53 P.M., the Social Services Director indicated she was new to the facility and the facility had recently changed companies to provide podiatry services. Resident 19 was on the list to be seen on 9/22/23. Ancillary services such as podiatry were part of the care plan process and should be addressed on the care plan. On 9/20/23 at 2:00 P.M., LPN 15 indicated after completing the resident's weekly skin assessment on 8/30/23, she had requested a podiatry consult from Social Services but didn't know the follow up process. On 9/21/23 at 10:16 A.M., the Director of Nursing provided a policy, titled "Personal Hygiene" which indicated "Diabetic nail care must be performed by a licensed nurse or podiatrist". The facility had no policy specific for foot care to prevent complications from conditions such as diabetes and peripheral vascular disease. 3.1-47(a)(7)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility.			

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	§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to ensure individualized contracture management interventions were in place for a resident with a decline in range of motion for 1 of 1 residents reviewed for range of motion (Resident 3). Findings include: On 9/19/23 at 11:20 A.M., Resident 3's record was reviewed. Diagnoses include dementia without behavioral disturbance, stroke with hemiplegia and hemiparesis of left non-dominant side, contracture of left wrist and diabetes. An annual MDS (Minimum Data Set) assessment, dated 4/4/23, indicated the resident has severely impaired cognition. He was dependent on staff for all ADL care and had range of motion impairment to both upper and lower extremities.	F 0688	1 Resident #3 was evaluated and picked up on therapy caseload for OT services to address trial of new upper extremity splint/orthotic and develop appropriate post discharge contracture management interventions for bilateral upper extremities and determine tolerance to interventions. Resident #3 has been picked on PT caseload to assess and address any interventions and recommendations for contracture management of bilateral lower extremities. Resident #3's care plan was reviewed and updated by IDT on 10/13/23. 2 All residents with contractures have the potential to be affected by this deficient practice. The list of all residents with contractures	10/31/2023

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	A care plan, revised on 7/24/19, indicated the resident had hemiplegia/hemiparesis on the left side due to a stroke. The goal was for his care plan interventions to minimize his risk for worsening contractures with a target date of 10/15/23. Interventions included: provide needed assistance with ADL's and provide assistance to resident with his restorative nursing program. On 9/18/23 at 11:16 A.M., Resident 3 was observed lying in bed. He could answer yes and no questions. His left hand was closed into a fist and his right hand was observed to have a couple of fingers extended upward and the other fingers, curled into a fist. He wore no splints or contracture management devices on either hand. On 9/21/23 at 9:21 A.M., the resident was observed lying in bed with his eyes closed. He wore no splints or contracture management devices on his hands. On 9/20/23 at 10:59 A.M., the Director of Nursing (DON) provided copies of therapy progress notes which indicated the following: Occupational therapy services, provided 3/25/22 through 4/23/22, indicated the resident had been seen to assist with trunk flexibility and safe upright sitting. Additionally, the resident would increase his ability to propel himself in his wheelchair 100 feet. His range of motion and strength assessment indicated he had impaired range of motion to his right elbow/forearm, wrist, and hand but were within functional limits (able to use the affected extremity functionally with everyday tasks). He had impaired range of motion and function to his left upper extremity. Occupational therapy services, provided		will be issued to the therapy department by 10/16/23 and all the residents on the list will be screened for appropriate interventions to address contracture management by 10/31/23. Residents identified for therapy intervention will be evaluated by therapy. 3 Nursing staff have been educated to utilize the therapy communication form for residents experiencing a decline in range of motion for therapy screening. Therapy will screen/evaluate residents with a decline in mobility/ROM for appropriate interventions and issue recommendations to physician and MDS/Director of Nursing Services. MDS will use the Therapy discharge recommendations to update care plans and the Director of Nursing will use Therapy discharge recommendations to develop and implement staff education on resident specific interventions. The IDT will review the current list of all residents with contractures during the monthly QAPI meeting to ensure appropriate contracture management interventions are in place until 100% compliance is reached. The Regional Therapy Manager will provide an in-service to therapy staff registered therapists to provide education on identification and documentation of discharge risk areas, appropriate	

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	8/19/22-9/17/22, indicated the resident's range of motion to his right elbow/forearm, wrist and hand were impaired and he no longer propelled himself. He required therapy services to address modifications to his current wheelchair seating system to improve his posture. There was no documentation provided for the change in the resident's functional limitations in his right extremity and change in ability to self propel in his wheelchair. The clinical record lacked indication of refusal of services by the resident. On 9/21/23 at 9:58 A.M., the Rehabilitation Director/Occupational Therapist indicated Resident 3 had been admitted with left sided spacticity and contractures and refused to wear contracture splints. He indicated the resident's condition declined over time and he had range of motion limitations and spacticity to his right side in addition to the left. Therapy had focused on positioning him in a Broda chair for comfort versus contracture care. On 9/21/23 at 3:10 P.M., the DON indicated the facility did not have a nursing restorative department. A CNA worked with therapy, however Resident 3 was not receiving a restorative range of motion program. Resident's measurement of degree of contractures and changes were not monitored by nursing staff but referred to therapy if changes were observed. A policy, titled "Restorative/ADL Nursing", was provided by the DON on 9/22/23 and stated " A resident with limited range of motion receives appropriate treatment and services to prevent further decline...A resident that shows a decline in range of motion will be referred to therapy. Range		discharge recommendations, and education on the new process for issuing written discharge recommendations to MDS and the director of Nursing. 4 The Regional Therapy manager will complete monthly audits for a period of 6 months to begin in November of 2023 and end with the month of April 2024 to ensure that the therapy department is issuing written discharge recommendations to the MDS team for all in-house therapy discharges and that the therapy team is reviewing the facility contracture list issued monthly. The IDT will review the current list of all residents with contractures during the monthly QAPI meeting to ensure appropriate contracture management interventions are in place until 100% compliance is reached.	

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	of motion exercises may be completed individually, in a group, or during am and/or pm care by facility staff trained to assist with range of motion exercises..." 3.1-42(a)(1)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview and record review the facility failed to ensure intravenous (IV) therapy was maintained and discontinued for 1 of 3 residents reviewed. (Resident 134) Findings include: On 9/20/23 at 9:04 AM Resident 134 was observed wearing a pink shirt with long sleeves. An IV site was observed to he lower arm. The resident indicated she had been waiting for the IV to be removed. There was no IV administration set observed in the resident's room. Resident 134's record was reviewed on 9/20/23 at 9:07 AM. Diagnoses included right lower leg fracture, torn cartilage of the right knee, emphysema and urinary tract infection (UTI). Resident 134's most recent discharge Minimum Data Set (MDS) dated 8/1/23 indicated their Basic Interview for Mental Status (BIMS) score was 15 (no cognitive deficit).	F 0694	1 Corrective action for resident 134 cannot be taken as the alleged deficiency occurred in the past. 2 All residents have the potential to be affected by the alleged deficiency. 3 Nurses will be in serviced on an updated policy for IV Management and Physician Notification related to IV administration. 4 DON/designee will monitor IV/Central Line usage to ensure proper administration of medication, physician notification of needed change in treatment and proper assessment and documentation of removal. This will occur 2 times per week for 8 weeks then weekly for 8 weeks then monthly for 2 months. Ongoing monitoring will occur monthly thru QA until 100%	10/31/2023

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	A physician order dated 9/12/23 indicated Resident 134 was to have an IV placed for antibiotic (ATB) therapy to treat a UTI. Resident 134's current physician orders did not include a prescribed ATB. Resident 134's Medication Administration Record (MAR), dated September 2023, indicated the resident was to be administered Meropenem intravenous solution (IV ATB) 500 milligrams (mg) IV every 8 hours for 11 doses starting 9/12/23. The MAR indicated the last dose was to be given on 9/16/23 at 12:00 AM. The MAR indicated Resident 134 was to be administered IV ATB on 9/12/23 at 6:00 PM. The MAR indicated the resident had been administered 9 doses of IV ATB. The MAR indicated the resident was administered IV ATB on the following dates: 9/13/23 at 12:00 AM 9/13/23 at 8:00 AM 9/13/23 at 4:00 PM 9/14/23 at 12:00 AM 9/14/23 at 8:00 AM 9/14/23 at 4:00 PM 9/15/23 at 12:00 AM 9/15/23 at 8:00 AM 9/16/23 at 12:00 AM A progress note dated 9/12/23 at 4:54 PM indicated the resident was awaiting IV placement. The progress note did not indicate the prescribing Nurse Practitioner (NP) had been made aware of the missed dose. A physician order dated 9/12/23 indicated Resident 134's IV site was to be observed every		compliance is achieved.	

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shift.

The September 2023 MAR indicated the IV site was observed every shift starting 9/12/23 on night shift through 9/20/23 on day shift.

Resident 134's clinical record indicated the IV was placed into the upper left arm on 6/13/23 at 6:35 PM. The September 2023 MAR indicated Resident 134 was administered the IV ATB, prior to the placement of the IV, on the following dates:

9/13/23 at 12:00 AM
9/13/23 at 8:00 AM
9/13/23 at 4:00 PM

In an interview on 9/20/23 at 11:28 AM the Administrator indicated the IV was scheduled for removal that day.

In an interview on 9/22/23 at 11:43 AM the Director of Nursing (DON) indicated there was no further information related to Resident 134 being administered 9 doses of the ATB instead of the 11 prescribed doses. The DON provided a copy of the September 2023 MAR which indicated the IV had been discontinued. The DON indicated there was no documentation related to the measurements of the IV catheter or the IV removal procedure. The DON indicated the facility did not measure the IV catheter after the removal. The NP had been made aware of the missed IV ATB dose due to the IV had not been placed until the next day. The DON indicated the NP had been made aware of the missed dose that day 9/20/23.

A current IV management policy dated 7/1/2012, provided by the DON on 9/22/23 at 12:59 PM, indicated a sterile antimicrobial dressing was to be applied to the IV insertion after IV removal. The

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	resident should be assessed, IV catheter measured, and the antimicrobial dressing was to remain in place for 24 hours. The policy indicated documentation of the procedure should include: Date and time Reason for removal Length, condition of catheter and tip integrity Site assessment Resident response to procedure Resident and/or family teaching. 3.1-47(a)(2)			
F 0725 SS=D Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under			

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	paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed to maintain adequate staffing levels to provide assistance with repositioning and personal care needs for 2 of 3 residents reviewed (Resident A and Resident B). Findings include: An anonymous complaint to the Indiana Department of Health indicated there was a concern the facility did not have enough staff to care for the residents. On 9/20/23 at 10:00 AM, Resident B's room mate was heard yelling for help. Resident B was observed with her lower body off the bed. On 9/20/23 at 10:04 AM, an unknown CNA inside Resident B's room was observed telling Resident B there was not enough staff. The CNA told Resident B they should have gotten up earlier in the day when other staff was available to assist. In an interview on 9/22/23 at 10:56 AM, Resident B indicated on 9/20/22 at 10:00 AM, they were trying to reposition to sit on the edge of the bed to relieve back pain, when they were unable to get back onto the bed and nearly fell. Resident B indicated the call light had been on awhile. Resident B's room mate indicated the nursing staff treated them like gold, but they were short staffed today. In an interview on 9/22/23 at 2:25 PM the Administrator indicated they had identified a staffing shortage in January 2023. The facility was currently hiring nurses and certified nursing aides	F 0725	1 Corrective action cannot occur as the alleged deficiency occurred in the past. 2 All residents have the potential to be affected by the alleged deficiency. 3 Facility assessment will be reviewed and updated to reflect facilities staffing needs. 4 HFA/designee will monitor staffing PPD to ensure it meets the Facility Assessments identified need. This will occur 5 times per week for 8 weeks then weekly for 8 weeks then monthly for 2 months. Ongoing monitoring will occur thru QA monthly until 100% compliance is achieved.	10/31/2023

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and utilized staffing agencies and consistently reviewed online employment searches.

The current Facility Assessment (used to determine staffing to meet resident needs) dated 1/1/23, provided by the Administrator on 9/18/23 at 1:40 PM, indicated the facility needed 78 hours of licensed nurses providing direct care daily. The facility assessment indicated the facility needed 180 to 200 hours of certified nurse aides daily.

A review of nurse and CNA hours as worked (calculated by the facility) for September 2023, provided by the Administrator on 9/22/23 at 3:35 PM, indicated the following days the facility established daily hours of CNAs to be 180-200 daily and direct care licensed nurse daily hours to be 78 were not met:

9/1/23-Nurse=48 CNA=161 CENSUS=79
9/2/23-Nurse=76 CNA=138 CENSUS=77
9/3/23- Nurse=72 CNA=145.5 CENSUS=79
9/5/23- Nurse=52 CNA=168.5 CENSUS=80
9/6/23- Nurse=56 CNA=173 CENSUS=81
9/7/23- Nurse=68 CNA=140 CENSUS=81
9/8/23- Nurse=52 CNA=154.5 CENSUS=79
9/9/23- Nurse=88 CNA=124 CENSUS=77
9/11/23-Nurse=56 CNA=131.5 CENSUS=77
9/12/23-Nurse=48 CNA=150.5 CENSUS=77
9/13/23-Nurse=64 CNA=136 CENSUS=77
9/14/23-Nurse=56 CNA=138 CENSUS=78
9/15/23-Nurse=60 CNA=132 CENSUS=78
9/18/23-Nurse=64 CNA=150 CENSUS=79
9/19/23-Nurse=64 CNA=135.5 CENSUS=80
9/20/23-Nurse=56 CNA=151 CENSUS=78
9/21/23-Nurse=48 CNA=157 CENSUS=79

Cross reference F550.

Cross reference F677.

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	09/22/2023

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
	This Federal Tag relates to Complaint IN00417481. 3.1-17(b)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to ensure kitchen sanitation for 76 of 79 residents currently residing in the facility who consume food prepared in the kitchen. Findings include: During a kitchen observation, with the Dietary Manager (DM) on 9/18/23 at 9:52 AM, two baking	F 0812	1 Corrective action cannot occur as the alleged deficiency occurred in the past. 2 All residents have the potential to be affected by the alleged deficiency. 3 Facility assessment will be reviewed and updated to reflect facilities staffing needs. 4 HFA/designee will monitor	10/31/2023

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	pans were observed with several 3-5 centimeter-sized brown debris stuck to the inner walls of each pan. Two additional pans were observed with liquid dripping from the inside of the pan upon separation. The DM indicated pans should be checked for cleanliness and moisture prior to stacking and storing. Multiple pencil eraser-sized tan and brown spots were observed throughout the cabinetry of the kitchen. Brown, white, and black pieces of debris were visible on the floors throughout the kitchen and walk in cooler. The debris ranged from pencil lead-sized to quarter-sized. A whole mushroom, a blue ring from a milk jug, and a plastic bread bag closure were on the floor of the kitchen. The DM indicated the debris on the floor was generated in more than just the last day. A housekeeper was scheduled to deep clean the kitchen floors the previous night and had called in sick. The dietary staff reported to her they did not have time to complete all their cleaning tasks. In the walk-in cooler, two cracked eggs were visible in the tray of whole eggs. The DM indicated each egg should be inspected, and eggs not contaminated with egg liquid should be placed in a clean tray, with cracked and contaminated eggs discarded. A jug of Worcestershire sauce had a use by date of 12/22. An open jug of sweet and sour sauce did not have an open date. In the walk-in freezer, an open container of ice cream did not have an open date. A plastic bag containing 5 pieces of Salisbury steak was tied		staffing PPD to ensure it meets the Facility Assessments identified need. This will occur 5 times per week for 8 weeks then weekly for 8 weeks then monthly for 2 months. Ongoing monitoring will occur thru QA monthly until 100% compliance is achieved.	

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	closed with no open date. A bag of crinkle-cut fries and a bag of Italian cut beans were observed open with no open dates. The DM indicated containers should be dated when opened. During an observation and interview with the DM on 9/18/23 at 11:29 AM, Dietary Aide (DA) 4 was observed carrying snack bags and cans of soda within her arms, pressed against her body. DA 4 then carried three clean juice pitchers from the clean dish area across the room to the storage cabinets with the pitchers within her arms, pressed against her body. The DM indicated DA 4 should have carried items away from her body to prevent contamination. During an observation and interview with the DM on 9/18/23 at 11:35 AM Cook 3 was observed with large, darkened spots covering over half of the outer thigh portion of her uniform pants. Light tan and brown spots, dime to quarter-sized, were observed scattered on the darkened portion of her uniform pants. Cook 3 was observed washing her hands for three seconds and wiping her hands on the darkened portion of her uniform pants as she returned to her workstation. Another handwash by Cook 3 was observed lasting 10 seconds. Cook 3 was observed several times in the meal preparation process going from the dirty dish area of the kitchen, performing a task, and returning to the steam table containing food to be served for lunch with no hand hygiene performed. The DM indicated Cook 3 should have washed her hands for at least 20 seconds and dried them with a paper towel when leaving a dirty area and going to a clean food area. In an interview on 9/22/23 at 9:28 AM, the Administrator indicated three residents currently residing in the facility received nothing by mouth.			

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	All other residents currently residing in the facility consumed food prepared in the kitchen. A current policy titled "Digital Food Labeling," dated 3/1/20 and provided by the Administrator on 9/19/23 at 8:36 AM, indicated all leftover foods or open packages must be promptly labeled to comply with food safety standards. A current policy titled "Handwashing," dated 10/17 and provided by the Administrator on 9/19/23 at 8:36 AM, indicated hands should be washed during food preparation to prevent cross contamination when changing tasks. Hands should be vigorously washed for at least 20 seconds and dried with a clean paper towel. A current policy titled "Cleaning Schedules," dated 6/20 and provided by the Administrator on 9/19/23 at 2:41 PM, indicated the dining and nutrition staff will maintain the cleanliness and sanitation of the dining and sanitation of the dining and food service areas through compliance with a written comprehensive cleaning schedule. 3.1-21 (a)(3)			