STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155003	A. BUILDING -- B. WING	10/02/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/02/23 Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600 At this Emergency Preparedness survey, Mason Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 115 and had a census of 77 at the time of this survey. Quality Review completed on 10/04/23	E 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. Mason is requesting paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/02/2023 Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600 At this Life Safety Code survey, Mason Health Care Center was found not in compliance with Requirements for Participation in	K 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. Mason is requesting paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rukiya Brooks	Administrator	10/16/2023

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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	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. This one story facility was determined to be of Type V111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 115 and had a census of 77 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/04/23			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.			

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	19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations (DPO) on 10/02/23 at 02:20 p.m., Activity office contained 10 boxes of supplies and wall to wall shelving filled with combustibles and was greater than 50 square feet making this a hazardous area. The Activity office was not protected as a hazardous area because the corridor door to the room did not self close and latch when tested. Based on interview at the time of observation, the DPO agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room did not self-close and latch when tested. The finding was reviewed with the Administrator	K 0321	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were identified. 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 residing on the hall have the potential to be affected. The activity staff removed boxes that were on the floor and properly stored supplies on the shelves. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	10/17/2023

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	and the DPO during the exit conference. 3.1-19(b)		recur; Supplies were removed from the floor and stored on the shelves. The maintenance director installed a closure on the door on 10-09-23. Activity staff were educated by the maintenance director on proper storage. 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 maintenance director will audit the area weekly for 8 weeks then monthly for 4 months to ensure compliance. The results of the audit will be discussed in QA monthly for 6 months or until 100% compliance is achieved.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) on 10/02/23 at 02:25 p.m. the facility has a supervised dry sprinkler system with three pressure gauges one of which that was dated 2016. No recalibration date information was affixed to the sprinkler system gauge. Based on interview at the time of the observations, the DPO agreed the one gauge was dated 2016, was older than five years and no information regarding replacement or recalibration was availble for review. This finding was reviewed with the Administrator and DPO at the exit conference. 3.1-19(b)	K 0353	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were identified. 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; VFP Fire System was contacted and replaced the outdated pressure gage on 10-12-23. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; VFP Fire System will complete quarterly inspections to ensure that the pressure gages are within 5 years old. 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	10/17/2023

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			VFP Fire System will complete quarterly inspections to ensure pressure gages are in compliance. The results of this inspection will be reviewed in QA quarterly for 6 months.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Director of Plant Operations (DPO) on 10/02/23 at 02:45 p.m., the oxygen transfilling room contained liquid oxygen tanks. The door to the room was not provided	K 0927	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were identified. 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 by the	10/17/2023

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	with a sign that indicating when transfilling of oxygen is occurring. Based on interview at the time of observation, the DPO stated there was not a sign that indicates when transfilling of oxygen is occurring and did not know that one was required. The finding was reviewed with the Administrator and the DPO during the exit conference. 3.1-19(b)		deficient practice. A sign that reads “vacant” and “in use” was placed on the outside of the door on 10-06-23. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A sign was placed on the outside of the door to indicate when the oxygen room is in use and empty. The staff will be in serviced on the use and meaning of the sign on 10-17-23. 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 maintenance director will ensure that the sign remains accessible for staff to use when in the oxygen room. The respiratory therapist will educate all new nursing staff on proper procedure while utilizing the oxygen room. The maintenance director will audit weekly to ensure the sign is in place for 8 weeks then monthly for 4 months or until 100% compliance is met.	