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	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mason Health Care Center	900 Provident Drive Warsaw, IN 46580

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45120 Based on interview, record review and interview, the facility failed to provide scheduled pain medication in a timely manner for 1 of 3 residents reviewed for pharmaceutical services. (Resident B) Finding includes: During an interview, on 3/5/2025 at 9:28 A.M., Resident B indicated RN 2 was not allowed to provide medical services for her, including medication administration. This decision was made due to a prior incident of RN 2 scaring her during a night shift medication administration. She indicated RN 2 had been informed the other evening and night shift nurses were to administer her pain medications when needed at 4:00 P.M., 8:00P.M., 12:00 A.M. and 4:00 A.M. when RN 2 was scheduled to work A record review for Resident B was completed on 3/5/2025 at 10:32 A.M. Diagnoses included, but were not limited to: leukemia, anemia and anxiety disorder. A Quarterly Minimum Data Set assessment, completed 2/13/2025, indicated Resident B was cognitively intact and received opioid pain medication. She had medically complex conditions including a diagnosis of cancer. A Physician's Order, dated 12/2024, indicated Norco (hydrocodone-acetaminophen) 7.5 milligrams-325 milligrams every four hours for pain management. The medication administration times included: 12:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M. A document titled, Grievance Form, was completed by the facility Executive Director on behalf of Resident B on 1/27/2025. The grievance indicated Resident B had concerns related to the administration of her Norco (pain medication) and Zofran (antiemetic medication) medications. The investigation indicated the Zofran and Norco were scheduled as needed and routine. These medications had been changed to routine times for medication administration. A Medication Administration Audit Report, dated 2/1/2025 through 3/5/2025, for second shift (2:00 P.M. through 10:00 P.M.), indicated the following administration times: for the Norco: -2/3/2025 scheduled at 8:00 P.M., administered at 9:42 P.M. -2/4/2025 scheduled at 4:00 P.M., administered at 5:30 P.M. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/4/2025 scheduled at 8:00 P.M., administered at 9:58 P.M. -2/6/2025 scheduled at 4:00 P.M., administered at 6:45 P.M. -2/7/2025 scheduled at 4:00 P.M., administered at 6:15 P.M. -2/8/2025 scheduled at 8:00 P.M., administered at 6:52 P.M. -2/10/2025 scheduled at 4:00 P.M, administered at 5:10 P.M. -2/14/2025 scheduled at 8:00 P.M., administered at 9:23 P.M. -2/16/2025 scheduled at 4:00 P.M., administered at 6:37 P.M. -2/18/2025 scheduled at 4:00 P.M., administered at 7:56 P.M. -2/24/2025 scheduled at 4:00 P.M., administered at 6:17 P.M. -2/25/2025 scheduled at 4:00 P.M., administered at 5:15 P.M. -2/26/2025 scheduled at 4:00 P.M., administered at 5:34 P.M. -3/2/2025 scheduled at 4:00 P.M., administered at 5:16 P.M. -3/2/2025 scheduled at 8:00 P.M., administered at 9:53 P.M. A Medication Administration Audit Report, dated 2/1/2025 through 3/5/2025, for the night shift (10:00 P.M. -6:00 A.M.) indicated the following administration times: -2/8/2025 scheduled at 12:00 A.M., administered at 2:36 A.M. -2/13/2025 scheduled at 4:00 A.M., administered at 5:57 A.M. -2/15/2025 scheduled at 4:00 A.M., administered at 5:19 A.M. -2/18/2025 scheduled at 2:00 A.M., administered at 10:35 P.M. -2/18/2025 scheduled at 4:00 A.M., administered at 10:35 P.M. -2/19/2025 scheduled at 4:00 A.M., administered at 5:07 A.M. -2/24/2025 scheduled at 4:00 A.M., administered at 5:05 A.M. During an interview, on 3/5/2025 at 1:02 P.M., RN 3 indicated there had been a communication problem with RN 2 communicating with the other licensed nursing staff to administer Resident B's pain medication during his scheduled shifts. She indicated a scheduled medication should have been administered within an hour before or an hour after the scheduled medication administration time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/5/2025 at 1:24 P.M., Resident B indicated that her pain level increased if she waited more than 40 minutes from the administration time to receive her pain medication. She indicated she would have to make sure she woke up during the night to ensure she received her pain medication. She indicated she had called the facility many times to have her pain medication administered to her or remind the staff to administer the medication. Resident B indicated she had spoken with RN 2 about his responsibilities to remind the other licensed nursing staff of her need to have her pain medication administered timely, and RN 2 indicated he would not inform the other staff as Resident B was not his responsibility. During an interview, on 3/5/2025 at 1:37 P.M., Resident B's daughter indicated she had had a conversation with RN 2 about his responsibility to inform the other licensed nursing staff of the need to administer Resident B's medications when he was scheduled to work. Resident B's daughter indicated he did not respond verbally to her request. A policy was provided by the Regional Director of Clinical Services, on 3/5/2025 at 2:09 P.M. The policy titled, Medication Administration, indicated, .12. Compare medication source [bubble pack, vial, etc.] with MAR [Medication Administration Record] to verify resident name, medication name, form, dose, route, and time .b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician This citation relates to Complaint IN00454167. 3.1-37(a)