

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/09/2026 |
| NAME OF PROVIDER OR SUPPLIER Mason Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
|--|---|
| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, record review and interview, the facility failed to provide privacy during incontinence care for 3 of 4 residents observed for activities of daily living. (Residents B, C & D) Finding includes: 1. During an observation, on 3/9/2026 at 4:44 A.M., Resident B was assisted by CNA (Certified Nursing Assistant) 2 and 3 with incontinence care. CNA 2 and 3 did not pull Resident B's privacy curtain between Resident B and his roommate. A record review for Resident B was completed, on 3/9/2026 at 7:33 A.M. Diagnoses included, but were not limited to: nontraumatic intracerebral hemorrhage, dementia and altered mental status. An admission Minimum Data Set (MDS) assessment for Resident B was in progress and had not yet been fully completed. Resident B did not have a care plan that addressed incontinence care. 2. During an observation, on 3/9/2026 at 5:22 A.M., Resident C was assisted by CNA 2 and 3 with the placement of an incontinence brief while lying in bed. CNA 2 pulled Resident C's lower garment to her ankles and placed the incontinence brief underneath Resident C. The privacy curtain had not been pulled between Resident C and her roommate, and the window blinds were not closed during the incontinence care. A record review for Resident C was completed on 3/9/2026 at 7:51 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, dementia and overactive bladder. An Annual Minimum Data Set (MDS) assessment, dated 12/19/2025, indicated Resident C had severe cognitive impairment and required substantial assistance for toileting hygiene. A Care Plan, initiated on 8/1/2023 and revised on 3/6/2026, indicated Resident C was incontinent of bladder and bowel at times. Interventions included, but were not limited to: assist Resident C with clothing adjustment, cleansing, and transfers during toileting and assistance with incontinence care. 3. During an observation, on 3/9/2026 at 5:40 A.M., Resident D was assisted by CNA 2 and 3. The privacy curtain by the window had been pulled, but not completely pulled to cover the exposed window at the end of the bed with the blinds open. The privacy curtain was not pulled between Resident D and her roommate. A record review for Resident D was completed, on 3/9/2026 at 8:15 A.M. Diagnoses included, but were not limited to: spastic hemiplegia, cerebral infarction and overactive bladder. A Quarterly MDS assessment, dated 12/22/2025, indicated Resident D had severe cognitive impairment, was always incontinent of bladder and bowel and was dependent for toileting hygiene. A Care Plan, initiated on 3/28/2023 and revised on 2/16/2026, indicated Resident D was incontinent of bladder and bowel. Interventions included, but were not limited to: staff would check for incontinence frequently as needed and assist with incontinence care. During an interview, on 3/9/2026 at 5:48 A.M., CNA 2 indicated the privacy curtains and the window blinds should have been closed or pulled when incontinence care had been provided. A policy was provided by the Executive Director, on 3/9/2026 at 8:35 A.M. The policy titled, Resident Rights, indicated, .The resident has a right to be treated with respect and dignity. 410 IAC 16-2-3.1-3(p)(4)</p> |

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 |
|---|-------|-----------|

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/09/2026 |
| NAME OF PROVIDER OR SUPPLIER Mason Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on observation, interview and record review, the facility failed to ensure staff changed gloves between soiled incontinence care and clean incontinence care for 3 of 4 residents observed for activities of daily living. (Residents B, C & D) Findings include: 1. During an observation, on 3/9/2026 at 4:44 A.M., Resident B was observed being assisted with incontinence care after having been incontinent of urine in his disposable brief. CNA (Certified Nursing Assistant) 2 and 3 assisted Resident B, while he was in his bed, with incontinence care. CNA 2 and 3 removed the soiled brief and CNA 3 provided peri care using disposable wipes. CNA 3 then, without changing her gloves, assisted with applying a new, clean incontinence brief to Resident B. A record review for Resident B was completed, on 3/9/2026 at 7:33 A.M. Diagnoses included, but were not limited to: nontraumatic intracerebral hemorrhage, dementia and altered mental status. An admission Minimum Data Set (MDS) assessment indicated it had not yet been completed and was in progress. Resident B did not have a care plan that addressed incontinence care. 2. During an observation, on 3/9/2026 at 5:22 A.M., Resident C was observed sitting on the edge of her bed wearing her daily clothing. Resident C did not have an incontinence brief on under her clothing. CNA 2 assisted Resident C with incontinent peri care by wiping her with disposable wipes. CNA 2 did not change her gloves after providing peri care before placing a clean incontinence brief on Resident C. A record review for Resident C was completed on 3/9/2026 at 7:51 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, dementia and overactive bladder. An Annual Minimum Data Set (MDS) assessment, dated 12/19/2025, indicated Resident C had severe cognitive impairment and required substantial assistance for toileting hygiene. A Care Plan, initiated on 8/1/2023 and revised on 3/6/2026, indicated Resident C was incontinent of bladder and bowel at times. Interventions included, but were not limited to: assist Resident C with clothing adjustment, cleansing and transfers during toileting and assistance with incontinence care. 3. During an observation, on 3/9/2026 at 5:40 A.M., Resident D was observed attempting to get out of bed. Resident D was noted to have a soiled incontinence brief in place. CNA 2 and 3 assisted Resident D with incontinence care. CNA 2 provided incontinent peri care, utilizing disposable wipes. After CNA 2 had provided peri care, she did not wash her hands or change her gloved before placing a clean incontinence brief on Resident D. A record review for Resident D was completed, on 3/9/2026 at 8:15 A.M. Diagnoses included, but were not limited to: spastic hemiplegia, cerebral infarction and overactive bladder. A Quarterly MDS assessment, dated 12/22/2025, indicated Resident D had severe cognitive impairment, was always incontinent of bladder and bowel and was dependent for toileting hygiene. A Care Plan, initiated on 3/28/2023 and revised on 2/16/2026, indicated Resident D was incontinent of bladder and bowel. Interventions included, but were not limited to: staff would check for incontinence frequently as needed and assist with incontinence care. During an interview, on 3/9/2026 at 5:48 A.M., CNA 2 indicated gloves should have been changed after providing incontinence care and before placing a clean incontinence brief on the residents. A policy was provided by the Executive Director, on 3/9/2026 at 8:35 A.M. The policy titled, Incontinence, indicated, .Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent Infections. 410 IAC 16-2-3.1-41(a)(2)</p> | | |