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	08/26/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure foods were stored, prepared and served in a sanitary manner in 1 of 1 kitchens reviewed. This deficient practice had the potential to affect 75 of 75 residents who received meals from the kitchen.Findings include: 1. During an observation of the kitchen, with the Dietary Manager on 8/18/2025 at 9:53 A.M., the following was observed:In the Walk in cooler:-1 cream cheese box not sealed.-an opened container of apple juice with a use by date of 8/17/2025. During an interview on 8/18/2025 at 10:00 A.M., the dietary manager indicated the foods should have been sealed appropriately and the juice should have been removed from the cooler. 2. In the walk in freezer:-a box of egg patties not sealed in the box with some patties having ice build up on them. During an interview, on 8/18/2025 at 10:10 A.M., the dietary manager indicated the box of egg patties should have been sealed. 3. In the dry storage area:-an opened package of spaghetti not sealed tightly.-an opened box of corn starch not sealed tightly.-an opened package of macaroni not sealed tightly. During an interview, on 8/18/2025 at 10:20 A.M., the dietary manager indicated the foods should have been sealed. 4.During a follow-up visit of the kitchen, on 8/19/2025 at 11:00 A.M., the following was observed:-the front of the steam table was noted to have a greasy substance dripped down the steam table. -2 dirty and 2 wet soup bowls put away as clean. During an interview, on 8/19/2025 at 11:06 A.M., the Registered Dietician indicated, they get to the steam table cleaning periodically. 5. During a follow-up visit of the kitchen, on 8/26/2025 at 10:16 A.M., the following was observed: -small & large skillets had missing Teflon coating to the cooking surfaces.-cooking pans had a build up of black grease to the bottom surface and around the handle of the pans.-steamer pans put away under the food prep table were wet. During an interview, on 8/26/2025 at 11:10 A.M., the cook indicated she had not had time to clean the steam table. On 8/25/2025 at 9:03 A.M., the Administrator provided the policy titled, Food Safety Requirements, dated 4/9/2024, and indicated the policy was the one currently used by the facility. The policy indicated . 1. Food safety practices shall be followed throughout the facility's entire food handling process . Elements of the process include the following: . e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food . c. iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by the use-by date, or frozen (where applicable)/discarded; and v. Keeping foods covered or in tight containers . 6. All equipment used in the handling of food shell be cleaned and sanitized, and handled in a manner to prevent contamination On 8/25/2025 at 9:03 A.M., the Administrator provided the policy titled, Steam Tables, dated 6/2021 and revised on 8/2025, and indicated the policy was the one currently used by the facility. The policy indicated . Steam tables will be maintained in a clean and sanitary condition. Steam tables should be cleaned after each use and thoroughly cleaned at least once per day . 3. Clean the inside and outside of each unit of the steam table 3.1-21(3)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155003	A. Building B. Wing	08/26/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure there were appropriate medical symptoms to support the use of an antipsychotic for 1 of 5 residents reviewed for unnecessary medications. (Resident 51) Finding includes: The record for Resident 51 was reviewed on 8/25/2025 at 10:43 A.M. Diagnoses included, but were not limited to Alzheimer's disease, depression, bipolar, psychotic disorder and dementia. A Quarterly MDS (Minimum Data Set) assessment, dated 6/9/2025, indicated the resident was unable to complete a mini mental assessment, and received an antidepressant and anticonvulsant medication. A Physicians Order, dated 6/29/2025, indicated Seroquel (antipsychotic) 25 mg (milligram) 1 tablet one time only for anxiety (1 time dose). During an interview, on 8/25/2025 at 3:37 P.M., the Director of Nursing indicated the diagnoses was not appropriate for the use of Seroquel. On 8/26/2025 at 11:45 A.M., the Corporate Nurse provided the policy titled, Unnecessary Drugs Policy, dated 2/5/2025, and indicated the policy was the one currently used by the facility. The policy indicated . Each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements: . c. Indications and clinical need for medication 3.1-3(w)

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	08/26/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure the care plan addressed the a diabetic resident's refusal of blood glucose monitoring for 1 of 1 residents reviewed for diabetic monitoring. (Resident 8)Findings include:The record for Resident 8 was reviewed on 8/22/2025 at 10:30 A.M. Diagnoses included, but were not limited to: Diabetes type 2, post-traumatic stress disorder, pulmonary hypertension with heart failure, restless leg syndrome and obesity. A Minimum Data Set (MDS) assessment, completed on 7/17/2025 indicated Resident 8 had no cognitive impairments, had a diabetes diagnosis and received insulin injections. The current Physician's orders for Resident 8 included the following diabetes management medications:Mounjaro Subcutaneous 10 milligrams (mg)/0.5 milliliter(ml) every Friday for diabetesJardiance 25 mg daily for diabetes Actos 15 mg daily for diabetesInsulin Glargine 100 units/ml 45 units subcutaneous twice a day for diabetesHumalog 100 u/ml, 10 units subcutaneous three times daily for diabetesDuring an interview, on 8/22/2025 at 10:20 A.M., RN 5 indicated resident 8's refusal of blood sugar checks started approximately a year ago. RN 5 indicated she was uncomfortable administering the numerous blood sugar medications to the resident without having assesed the resident's blood sugar level. RN 5 indicated Resident 8 had a physician's order to check blood sugars as needed if the resident exhibited signs or symptoms of hypo or hyperglycemia. During an interview, on 8/22/2025 at 1:20 P.M., Resident 8 indicated that she has been on the same medications for a long time and she did not feel she needed to check her blood sugar three times a day. She indicated she had tried a continuous glucose monitoring device but had not liked how painful it was to attach and detach from her arm. The current care plans related to diabetes for Resident 8 included a plan, initiated on 4/2/2024, with a problem that the resident may have fluctuating blood glucose levels. The care plan did not address the resident's refusal to have her blood glucose levels assessed. During an interview, on 8/26/25 at 11:09 A.M., the Director of Nursing indicated the resident's refusal for blood sugar checks should have been care planned. She indicated the facility did not have a specific policy regarding diabetic management. 3.1-35(b)(2)

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	08/26/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs) related to showering for 1 of 2 residents reviewed for ADL care. (Resident 40) Finding includes:During an interview, on 8/19/2025 at 11:04 A.M., Resident 40 indicated the last shower she had was approximately eight days ago. A record review was completed for Resident 40 on 8/22/2025 at 9:18 A.M. Diagnoses included, but were not limited to: type 2 diabetes, depression and need for assistance with personal care. An admission MDS assessment, dated 3/11/25, indicated it was very important for the resident to choose between a bed bath, shower, or tub bath. A Quarterly Minimum Data Set (MDS) assessment, dated 6/11/2025, indicated Resident 40's cognition was moderately impaired and the resident required substantial/maximum assistance from staff with bathing and showering. A current Care Plan, initiated on 3/8/2025 indicated Resident 40 needed assistance with ADL's. Interventions included, but were not limited to: the resident required the assistance of one person with bathing. The Care Plan also indicated Resident 40 had specific choices related to her care. Interventions included, but were not limited to: the resident preferred showers and would receive them two times per week per facility shower schedule. A review of Resident 40's shower task indicated Resident 40 had received showers on the following dates: -6/9/2025-6/16/2025-6/24/2025-7/31/2025-8/7/2025-8/14/2025 A review of Resident 40's bed bath task indicated the resident had received a bed bath on the following dates: -7/13/2025-7/24/2025-7/28/2025-8/11/2025-8/21/2025 Thus, Resident 40 had only received 11 of 22 care planned bathing opportunities and 5 of the 11 received were not her preferred method of bathing, showers. During an interview, on 8/26/2025 at 9:36 A.M., the ED indicated Resident 40 should have been receiving two showers per week.On 8/26/2025 at 11:21 A.M., the ED provided the policy titled, Resident Showers, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. 1. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. 2. Partial baths may be given between regular shoer schedules as per facility policy 3.1-38(b)(2)

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	08/26/2025

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. Based on record review and interview, the facility failed to notify the physician for significantly elevated blood glucose levels for 2 of 3 residents reviewed for blood glucose (Resident 32 & B).Findings include: 1. A record review was completed for Resident 32 on 8/20/2025 at 1:52 P.M. Diagnoses included, but were not limited to: type 2 diabetes. A Physician's Order, dated 8/6/2024 indicated a fasting blood glucose level was to be completed every morning one time per day and to notify the Nurse Practitioner if the resident's blood glucose level was below 70 mg/dl or above 400 mg/dl. A review of Resident 32's blood glucose levels indicated the resident's record lacked documentation the physician or Nurse Practitioner was notified of the resident's elevated blood glucose levels above 400 mg/dl for the following dates and times: -On 2/28/2025 at 7:37 A.M., Resident 32's blood glucose level was 443 mg/dl. -On 3/4/2025 at 10:11 A.M., Resident 32's blood glucose level was 546 mg/dl. -On 3/7/2025 at 9:19 A.M., Resident 32's blood glucose level was 436 mg/dl. During an interview, on 8/25/2025 at 10:43 A.M., RN 2 indicated if a resident's blood glucose level was outside the recommended parameters, they were supposed to notify the Nurse Practitioner and complete a progress note. During an interview, on 8/25/2025 at 11:03 A.M. the DON indicated the Nurse Practitioner should have been notified of Resident 32's elevated blood glucose levels. 2. The record for Resident B was reviewed on 8/22/2025 at 2:45 P.M. Diagnoses included, but were not limited to Cerebral infarct, dysphagia, severed protein calorie malnutrition, obstructive and reflux uropathy, diabetes type 2, acute kidney failure, adult failure to thrive and neuromuscular dysfunction of the bladder. An admission MDS (Minimum Data Set) assessment, dated 4/4/2025, indicated the resident was alert and oriented and was able to make his needs know, required extensive staff assist with transfers, bed mobility and showering and had an indwelling catheter. Physician's Orders, dated 4/2/2025, indicated the facility was to check the resident's blood sugar levels two times daily. The blood sugar documentation, dated 4/2/2025 through 4/18/2025 indicated the lowest blood sugar level result was 112 to the highest result of 313. The blood sugar documentation, dated 4/19/2025, indicated the following results: 329 at 4:38 A.M., 320 at 11:36 A.M., and 323 at 4:03 P.M. The blood sugar documentation, dated 4/20/2025, indicated the following results: blood glucose level was 319 at 7:13 A.M., the blood glucose level was 352 at 11:01 A.M., and the blood glucose level was 397 at 4:25 P.M. (continued on next page)

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	08/26/2025

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	During an interview, on 8/26/25 at 9:12 A.M., LPN 11 indicated if a resident had a high blood glucose level, she would first call the NP (Nurse Practitioner) to get orders and go from there. If the resident had no insulin orders, she would call the NP and put this in the progress notes and let the Director of Nursing and Assistant Director of Nursing know. During an interview, in 8/26/2025 at 9:48 A.M., the Director of Nursing indicated the physician should have been notified of the elevated blood glucose levels and a progress note should have been completed at the time of the notification. Progress Notes, dated on 4/18 and 4/19/2025, lacked the documentation of the physician being notified of the abnormal levels. On 8/25/2025 at 11:29 A.M., the Administrator provided the policy titled, Following Physician Orders/Parameters, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To administer resident care in a safe and effective manner and following physicians orders and ordered parameters. 2. Licensed healthcare personnel will consult and follow the physician/clinician order when performing any resident procedures This deficiency is related to intake 2594043. 3.1-37

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	08/26/2025

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, record review and interview, the facility failed to ensure 1 of 3 residents reviewed for hearing and/or vision needs had their audiologist recommendation followed in a timely manner. (Resident 3)Finding includes: During an interview, on 8/18/2025 at 3:38 P.M., Resident 3 indicated she was hard of hearing. The record for Resident 3 was reviewed on 8/26/2025 at 7:16 A.M. Diagnoses included anemia, hypotension, hyperkalemia, unspecified hearing loss bilateral and atrial fibrillation. A Quarterly MDS (Minimum Data Set) assessment, dated 8/18/2025, indicated Resident 3 was alert and oriented and her ability to hear was highly impaired/absence of useful hearing. A Care Plan, initiated on 5/15/2024, indicated the resident had a communication deficit as evidenced by hearing loss. The plan indicated the following: I prefer that others communicate with me in writing. I often speak loudly related to my hearing loss. During an interview on, 8/21/2025 at 10:48 A.M., the Social Service Director indicated the resident had been seen by the audiologist in December 2024. An audiology Visit Summary form, dated 12/9/2024, indicated the following: Medical consult to obtain medical clearance for hearing aids - continue with current means of communication. Medical consult due to Eustachian tube dysfunction- left ear- if bilateral tinnitus persists- both ears. Hearing aid is recommended, Type BTE binaural impression taken: YES There was no evidence in the medical record that the resident had been referred to an audiologist for a hearing aid. During an interview, on 8/26/2025 at 11:13 A.M., the Social Service Director indicated the referral should have been scheduled. On 8/26/2025 at 11:23 A.M., the Corporate Nurse provided the policy titled, Hearing an Vision Services, dated 3/5/2024, and indicated the policy was the one currently used by the facility. The policy indicated .It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated . 3. The social worker/social service designee is responsible for assisting residents, and their families in locating and utilizing any available resources . provision of the vision and hearing services the resident needs. 3.1-39(a)

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	08/26/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure the narcotic (controlled substance) inventory book was completed thoroughly and accurately on 1 of 2 medication carts. (100 hall cart) Findings include:During an observation, on 8/22/2025 at 10:20 A.M., The narcotic card count sheet for the 100 Hallway medication cart lacked 8 signatures out of 72 opportunities. During an interview, on 8/22/2025 at 10:22 A.M., RN 5 indicated that the on coming and off going medical personnel who performed the narcotic inventory were responsible for signing the narcotic inventory book. RN 5 indicated staff should have signed the inventory book after the count was completed. On 8/25/2025 at 3:35 P.M., the Executive Director provided a policy titled Controlled Substance Administration and Accountability. The policy indicates, .two licensed nurses account for all controlled substances and access keys at the end of each shift. 3.1-25(e)(3)

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	08/26/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered according to physician's orders and professional standards for 5 of 30 opportunities, resulting in a medication administration error rate of 16.67%. (Resident 73 and 9) During an observation, on [DATE] at 9:02 A.M., RN 2 was administrating medications to Resident 73. RN 2 indicated he had 11 pills in the medication cup. The medication administered to Resident 73's were: Cymbalta 20 milligrams (mg), one tablet for depression Finasteride 5 mg, one tablet for benign prostatic hypertrophyFloranex probiotic one tabletPlavix 75 mg, one tablet for prophylaxis of blood clotsFerrous Sulfate 325 mg, one tablet for iron supplementationMetformin 500 mg, one tablet for diabetesMetoprolol Tartrate 25 mg, give 0.5 tablet for hypertensionTylenol 650 mg, one tablet for painVascepa 1 gram, give 2 tablets for hypertriglyceridemia Vitamin C 500 mg, one tablet for vitamin supplementation During a record review, on [DATE] at 9:20 A.M., Resident 73 had been prescribed Docusate 100 mg tablet daily on [DATE]. This medication was on a separate roll of pills in the medication cart. During an interview with RN 2, he indicated that he thought he had given the Docusate medication. However, during the initial medication pass observation only 11 pills were counted in the cup. The Docusate medication would have brought the count to twelve. During at observation, on [DATE] at 2:08 P.M.of the medication cart on the 400 hallway, a multi-use vial of insulin Lispro 100 units per milliliter had an opened date of [DATE]. RN 2 indicated he had ordered a refill for the insulin and it should arrive today. RN 2 indicated opened multi-dose insulin vials were to be discarded after 30 days. The record for Resident 9 reviewed on [DATE] at 3:11 P.M., indicated the resident had a diagnosis including diabetes. A current Physician's Order, dated [DATE], indicated Insulin Lispro sliding scale coverage subcutaneously before meals and at bedtime for blood glucose levels greater than 350. Review of the Medication Administration Record (MAR) for August indicated Resident 9 had received sliding scale coverage on [DATE] at 4:58 P.M., [DATE] at 8:36 P.M., [DATE] at 9:32 P.M. and [DATE] at 7:22 P.M. During an interview, on [DATE] at 9:15 A.M., RN 6 and QMA 7 indicated opened vials of insulin were to be discarded after 28 days per the facility's pharmacy recommendations. Thus, the resident received 4 doses of Lispro insulin from an expired multi-use pen that had been opened on [DATE] and had expired on [DATE]. On [DATE] at 3:25 P.M., the Executive Director provided a policy titled, Insulin Administration dated 12/2021 and indicated this was the policy the facility uses. The policy indicated, Opened vials can be kept in the medication cart until used or expires (28 days after opening). 3.1-48(c)(2)

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	08/26/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to secure and destroy discontinued controlled medications and properly dispose of expired medications on 1 of 2 medication carts and in 1 of 1 medication storage room observed. (Medication cart 100 hallway and Medication storage room [ROOM NUMBER]-400 hallway)Findings include:During an observation, on 8/22/2025 at 10:20 A.M., in the top drawer of the 100 hall medication cart, two Lorazepam 0.5 mg tablets medication cards for Resident 66 that had been discontinued on 8/4/2025 were found. One card contained 10 Lorazepam 0.5 mg tablets and one card contained 60 Lorazepam 0.5 mg tablets. During an interview, on 8/22/25 at 10:20 A.M., RN 5 indicated she had discovered the discontinued medication during the morning narcotic count and had removed the cards from the narcotic drawer of the medication cart. RN 5 indicated she intended to have the medications destroyed but was interrupted before she could take them to the appropriate area for disposal. RN 5 indicated the medication should have been destroyed on 8/4/2025 and she should have returned the medication to the locked narcotic box until it could properly be destroyed. During an observation, on 8/25/25 at 2:00 P.M., an unopened insulin lispro pen for Resident 9 was found in the medication storage room refrigerator on the 300/400 hall. The insulin pen had an expiration date of 5/20/2024. During an interview, on 8/25/2025 at 2:00 P.M., RN 5 indicated the insulin pen should have been discarded on the expiration date. On 8/25/25 at 3:25 P.M., the Executive Director (ED) provided a policy titled Controlled Substance Administration and Accountability dated 11/01/2023 which stated, .the charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances Medications removed from a medication cart have a documented physician order. On 8/25/25 at 3:25 P.M., the ED provided a policy titled, Destruction of Unused Drugs dated 11/01/2023 which stated, .the sealed container must be maintained in a secure area of the pharmacy or in a locked cabinet in the medication room until transferred to the waste disposal service 3.1-25 (m)(n)(o)

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	08/26/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure staff followed infection control practices during a skin treatment for 1 of 1 skin treatments observed. (LPN 4) Finding includes: During an observation, on 8/18/2025 at 11:36 A.M., LPN 4 completed a wound treatment. LPN 4 placed her treatment supplies, including a pair of bandage scissors, directly onto the residents' table without placing a barrier down between the table and the supplies. LPN 4 then removed the residents' sock, the elastic bandage and then the gauze from the resident's right lower leg and removed the dressing to the heel and placed them in the trash can. LPN 4 then removed her gloves and applied hand sanitizer on both hands. She then, with opened hands, used a fanning motion to dry her hands and then applied new gloves. During an interview, on 8/18/2025 at 11:53 A.M., LPN 4 indicated she should have not fanned her hands and should have placed a barrier on the table. On 8/25/2025 at 4:30 P.M., the Corporate Nurse provided the policy titled, Hand Hygiene, dated 5/29/2024, and indicated the policy was the one currently used by the facility. The policy indicated . 4. Hand hygiene technique when using an alcohol-based hand rub: . b. Rub hands together, covering all surfaces of hands and fingers until hands feel dry. c. This should take about 20 seconds 3.1-18(a)