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 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. (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	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. 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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure urine outputs were monitored for a resident with an indwelling catheter for 1 of 1 residents reviewed for catheters. (Resident B) Finding includes:The record for Resident B was reviewed on [DATE] 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 [DATE], indicated the resident was alert and oriented and was able to make his needs known, required extensive staff assist with transfers, bed mobility and showering and had an indwelling catheter.Physician orders related to the resident's indwelling catheter included the following: 4/42025---Change catheter as needed; Change Catheter drainage bag as needed, and Catheter care every shift.A Nursing Progress Note, dated [DATE] at 8:54 A.M., indicated there was no change in urinary output. The resident's urine was clear and the indwelling catheter was draining to gravity.A Physician's Order, dated [DATE], indicated to remove the Foley indwelling urinary catheter for a voiding trial.A Nursing Progress Note, dated [DATE] at 4:41 P.M., indicated there had been no urine output produced so far during the voiding trial and it had been 7 hours (since the indwelling urinary catheter had been removed). Resident B was straight cathed (a procedure where a small thin hollow tube was inserted into the bladder to drain and collect urine from the bladder) which resulted with 250 cc of urine. The Nurse Practitioner ordered the resident to be straight cathead in 6 hours if no urine was produced and voided by the resident.A Nursing Progress Note, dated [DATE] at 11:23 P.M., indicated the resident had complained of urethra pain. A Nursing Progress Note, dated [DATE] at 11:46 P.M., indicated the Foley indwelling urinary catheter was reinserted because the resident was unable to void. There was a return of 600 cc's of clear yellow urine and the resident had complained of urethra pain when the catheter was reinserted. A Nursing Progress Note, dated [DATE] at 10:03 A.M., indicated no change in urine output, urine is clear. Has indwelling catheter draining to gravity. A Physician's Order, dated [DATE], indicated to obtain a UA-(urinalysis) lab test. A C&S (culture and sensitivity) laboratory test was ordered if indicated by the results of the urinalysis.A Nursing Progress Note, dated [DATE] at 5:02 P.M., indicated urine yellow in color, slight odor noted. UA C&S results pending at this time.A Nursing Progress Note, dated [DATE] at 3:45 A.M., indicated no change in urine output, urine is clear. Has indwelling catheter draining to gravity. A Nursing Progress Note, dated [DATE] at 8:00 P.M., as a late entry indicated 175 ml (milliliter) return with straight cath. Resident had voided less than 50 ml prior to cath. He had also urinated in his brief which was wet but not soaked. Urine clear yellow. No odor.A Physician Order, dated [DATE], indicated- straight Cath until resident voids independently then DC (discontinue).A Nursing Progress Note, dated [DATE] at 9:22 A.M., indicated no change in urine output. Urine is clear. Has indwelling catheter draining to gravity.A Nursing Progress Note, dated [DATE] at 9:54 A.M., resident urinated on his own. Will dc order for straight cath.A Nursing Progress Note, dated [DATE] at 6:25 P.M., indicated the urine results were: 10,000 to 50,000 organisms/candida glabrata (yeast that causes opportunistic life threatening infections). Nurse Practitioner aware. A Physician's Order, dated [DATE], included Ceftriaxone (a broad spectrum antibiotic) IM (intramuscular) x1 on [DATE].A Nursing Progress Note, dated [DATE] at 1:35 A.M., indicated no change in urine output. Urine is clear. Has indwelling catheter draining to gravity.A Physician Order, dated [DATE] at 11:02 A.M., included Pyridium (urinary tract analgesic) 200 mg 1 tablet every 6 hours as needed for urinary pain.A Nurses Progress Note, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE] at 2:21 P.M., indicated resident voided yellow urine with no issues. Incontinent of bowel/bladder.A Nursing Progress Note, dated [DATE] at 9:17 A.M., indicated no change in urine output. Urine is clear. Has indwelling catheter draining to gravity.A Nurses Progress Note, dated [DATE] at 12:22 P.M., indicated Resident B had urinary pain and had been medicated with the Pyridium medication.A Nurse Progress Note, dated [DATE] at 7:14 P.M., indicated Resident B had requested the Pyridium medication for urinary pain.A Nurse Progress Note, dated [DATE] at 10:25 P.M., indicated Resident B had requested the Pyridium medication for urinary pain.A Nurses Progress Note, dated [DATE] at 9:20 A.M., indicated the Foley catheter was discontinued due to soiled and dislodged.A Nursing Progress Note, dated [DATE] at 1:24 P. M., indicated no change in urine output. Urine is clear. Has indwelling catheter draining to gravity.A Nursing Progress Note, dated [DATE] at 10:23 A.M., indicated no change in urine output. Urine is clear. Has indwelling catheter draining to gravity.A Nurse Progress Note, dated [DATE] at 2:33 P.M., indicated Resident B had requested the Pyridium medication for urinary pain.A Nursing Progress Note, dated [DATE] at 9:59 A. M., indicated no change in urine output. Urine is yellow colored. Is continent of bladder.A Nurse Progress Note, dated [DATE] at 10:32 A.M., indicated Resident B had requested the Pyridium medication for urinary pain.A Nursing Progress Note, dated [DATE] at 5:13 A.M., indicated no change in urine output. Urine is yellowed color. Is continent of bladder.The clinical record lacked the documentation, from 4/18 to [DATE], to show the physician was notified of the continued urethral pain.During an interview, on [DATE] at 11:39 A.M, the Director of Nursing indicated the resident had an indwelling Foley catheter when he was transferred to the hospital on [DATE].Resident B was transferred to the the hospital emergency room on [DATE] because of a change in condition.The Emergency Department documentation, dated [DATE], indicated the following: chief complaint: sepsis (potentially life threatening infection) alert, recent stroke and apnic (loss of respiration) spells. Temperature was 100.2 degrees; blood pressure was 91/59; and his heart rate was 120 beats per minute. A urinalysis test (examination of the urine) obtained in the ER indicated the urine had a high number (41-99) of WBC (white blood cells), a high number (11-40) of RBC (red blood cells) and a high number (4+) of bacteria in the urine, which indicated a urinary infection. At 3:55 P.M., on [DATE], other Emergency documentation indicated the following: 1. Marked increase in the findings of active pneumonia in the lungs, and an element of pulmonary edema (liquid in the lungs) could also be present. 2. Findings of acute jejunitis (inflammation of the lining in the small intestine), and low grade colonic inflammation. 3. Bladder wall thickening could relate to cystitis or outlet obstruction. Residuals despite the presence of a Foley catheter, catheter dysfunction is suspected Emergency Department discharge instructions, dated [DATE] at 12:52.A.M indicated the resident had expired. A request for documentation of Resident B's urine outputs from [DATE] through [DATE] was made on [DATE] at 1:56 P.M.The facility indicated on [DATE] at 2:10 P.M., they could not provide Resident B's urine output amounts and indicated there should have been documentation of urine outputs for any resident with a Foley (urinary) catheter. During an interview, on [DATE] at 2:15 P.M., the Corporate Nurse indicated they did not have a policy regarding obtaining and documenting urine outputs for residents with urinary catheters.\This deficiency is related to intake 2594043.3.1-41(a)(2)