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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155804 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/19/2015 |
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| F 000 Bldg. 00 | <p>This visit for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: March 12, 13, 16, 17, 18 & 19, 2015</p> <p>Facility number: 013017 Provider number: 155804 AIM number: 201237680</p> <p>Survey team: Shauna Carlson, RN - TC (3/12, 3/13, 3/17, 3/18, 3/19, 2015) Julie Baumgartner, RN Pamela Williams, RN Amy Miller, RN</p> <p>Census bed type: SNF: 45 SNF/NF: 15 Residential: 26 Total: 86</p> <p>Census payor type: Medicare: 42 Medicaid: 15 Other: 3 Total: 60</p> <p>Residential sample: 7</p> | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| F 242 SS=D Bldg. 00 | <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on March 25, 2015, by Brenda Meredith, RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to give showers on scheduled shower days for 2 of 3 residents reviewed for choices. (Resident #167 and Resident #195)</p> <p>Findings include:</p> <p>1. During an interview on 3/13/2015 at 10:20 A.M., Resident #195 indicated "... shower schedule is Monday and Wednesday but no one has ever offered</p> | F 242 | This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Sprenger Health Care of Mishawaka agrees with the allegations and citations listed on this statement of deficiencies. Sprenger Health Care of Mishawaka maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of | 04/17/2015 |

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| | <p>me a shower...I have gone over a week without a shower...."</p> <p>On 3/16/15 at 10:52 A.M., a clinical record review was conducted for resident #195. The MDS (Minimum Data Set) assessment, dated 2/17/15, indicated the BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment and showers two times weekly.</p> <p>On 3/17/15 at 9:10 A.M., review of the "Shower/bath Skin Check" form for Resident #195 indicated no showers had been documented.</p> <p>On 3/18/15 at 10:17 A.M., review of the CNA (Certified Nursing Assistant) assignment sheet for Resident #195 indicated "...Bath/ Shower wed/sat evening...."</p> <p>2. During an interview on 3/16/15 at 11:40 A.M., Resident #167 indicated "...when I get a shower it's therapy that gives it to me...the CNA's don't. I don't usually get showers twice a week...one time I think I did."</p> <p>On 3/16/15 2:10 P.M., a clinical record review was conducted for resident #167. The MDS assessment, dated 1/22/15, indicated a BIMS score of 14, indicating</p> | | <p>such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Sprenger Health Care of Mishawaka written credible allegation of compliance. By submitting this plan of correction, Sprenger Health Care of Mishawaka does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Sprenger Health Care of Mishawaka reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding. Completion dates are listed within the POCF2421. Resident 195 has since been discharged to the Assisted Living on 3/24/15. Resident 167 has since been discharged following a successful rehabilitation stay on 3/20/15</p> <p>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. The facility Performed resident interviews to current residents to obtain additional information that includes shower preferences</p> <p>3. A new scheduler has been hired and has been appropriately trained on scheduling showers for residents. The nursing department has been educated on the regulation as it relates to resident choices that includes</p> | |

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| | <p>no cognitive impairment and showers two times weekly.</p> <p>On 3/17/15 at 9:12 A.M., review of the "Shower/ Bath Skin Check" form for Resident #167 from 1/31/15 to 3/21/15 indicated only 5 showers were performed.</p> <p>On 3/18/15 at 10:20 A.M., review of the CNA Assignment Sheet" for Resident #167 indicated "...Bath/Shower wed/sat days...."</p> <p>During an interview on 3/16/15 at 1:04 P.M., LPN (Licensed Practical Nurse) #4 indicated "...if a resident refuses a shower or bath it should be documented by the CNA on the shower/bath skin check sheet and in POC [Point of Care, computer charting system] as patient refusal...."</p> <p>On 3/17/15 at 9:07 A.M., the current undated policy, "Bathing Frequency," was provided by the ED (Executive Director). The policy indicated, "...1. A routine bathing schedule will be posted...."</p> <p>During an interview on 3/17/15 at 11:15 A.M., the ED indicated, "I have no CNA shower sheets from the POC system for Resident #167 or Resident #195."</p> <p>On 3/18/15 at 9:13 A.M., the form</p> | | <p>performing showers and documenting by 4/17/15. Nursing administration and/or designee will review shower sheets daily.</p> <p>4 The Nursing Administration team will perform audits on resident showers twice a week for 6 weeks and then monthly thereafter for total of 6 months. Results of those audits will be forwarded to QA&A monthly for 6-months and quarterly thereafter until compliance. Date of compliance 4/17/15</p> | |

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| F 371 | <p>"Showers by Day," updated on 12/1/14, was provided by the DON (Director of Nursing). The form indicated Resident #167 should receive showers on day shift on Wednesday/Saturday, Resident #195 should receive showers evenings on Wednesday/Saturday.</p> <p>During an interview on 3/16/15 at 2:36 P.M., the ED indicated ".... I know we have a problem with the showers... the scheduler is responsible for scheduling showers in the system once a resident has been admitted... we haven't had a scheduler since October 2014... that is where the break down is...shower sheets should be filled out with every shower...if on their own or if they refuse... if a resident refused or did it on their own the CNA documents it on a skin sheet ... and in the system...."</p> <p>3.1-3(u)(3)</p> <p>483.35(i)</p> | | | |

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| SS=F Bldg. 00 | <p>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure meals were being served under sanitary conditions in regards to proper food storage, handling and proper use of hairnets. This had the potential to affect 83 out of 87 residents that received meals from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>On 3/12/15 between 11:05 A.M. and 11:50 A.M., during the initial kitchen tour with the DM (Dietary Manager), the following was observed:</p> <p>The DM was observed the have the left side of her bangs hanging out of her hairnet.</p> <p>In the walk in freezer: *An open, undated, 30 pound bag of mixed peas and carrots. *An open to air, undated, 30 pound bag of green beans. *An open to air, undated, 30 pound bag of cauliflower.</p> | F 371 | <p>F3711. In the Walk in Freezer the items identified have been discarded. Other frozen products have been dated according to the manufactures recommendation. Employee 6, 7, & 8 were not identified during the observation, Employees of the Dietary have been informed that the hair needs to be covered in food preparation areas. In the Dry Storage, items identified were discarded. In the Walk in Cooler items identified have been discarded. In the dish room area a closed cabinet has been obtained to remove the chemicals off of the rack. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. The Registered Dietitian has performed a sanitation review to ensure no other items were identified. The Nursing and Dietary department have been educated on the policy as it relates to food dating, food Storage, hair net usage, and serving food by 4/17/15 3. The Registered dietitian will perform monthly sanitation audits. Executive director/designee will perform dining room observations twice a week for 6 weeks and</p> | 04/17/2015 | | | |

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| | <p>*An open to air, undated, box of chocolate chip read to bake cookies.</p> <p>*An open to air, undated, bag of Southern Style biscuits.</p> <p>*An open, undated, 10 pound bag of dinner rolls.</p> <p>*An open, undated, bag of wheat dinner rolls.</p> <p>*An open, undated, bag of Italian bread dough.</p> <p>*An open, undated, bag of diced chicken.</p> <p>*An open, undated, box of bacon.</p> <p>The DM indicated at this time, "We do not date them... they have a delivery date on them and if we use them by the allotted time we don't need to date them...."</p> <p>In the dry storage:</p> <p>*An open, undated, container of honey.</p> <p>*An open to air, undated, 10 pound box of lasagna noodles.</p> <p>The dietary manager indicated at this time, "The honey should be datedthe lasagna box should be closed and dated...."</p> <p>In the walk in cooler:</p> <p>*An open, undated, 5 pound bag of shredded cheddar cheese.</p> <p>*An open, undated, 5 pound bag of sweet diced apples.</p> <p>*An open, undated, bag of hard salami.</p> <p>The DM indicated at this time, "Yes they</p> | | <p>then monthly thereafter until 6 months of audits are completed. Department managers will be assigned to dining rooms to ensure meal delivery occurs as per policy.4. The Dietary Manager and/or the Executive Director will report on the sanitation reviews monthly for a period of 6 months.. Results of those audits will be forwarded to QA monthly for period of 6 months or until compliance is achieved</p> | |

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| | <p>should have dates on them...."</p> <p>*An open bag of diced ham, dated 3/8/15. The DM indicated at this time, "It should only be kept 3 days then thrown out...."</p> <p>*A partial head lettuce with brown edges, wrapped in plastic wrap dated 3/2/15. The DM indicated at this time, "We dispose of it when it's bad... yes this lettuce is bad...."</p> <p>On a storage rack in the kitchen next to the 3 compartment sink:</p> <p>*One 2.6 gallon bottle of "Convo Clean New" oven cleaner.</p> <p>*One 8 pound bottle of "Metal Safe " dish detergent.</p> <p>*One 1 gallon of "Crystal Dry" rinse aid. The DM indicated at this time, "Yes, we store some of our chemicals here...."</p> <p>On 3/12/15 from 11:51 to 12:15 P.M., observation of the lunch meal was conducted in the main dining room. During this time the following were observed:</p> <p>At 11:51 A.M., Employee #6 was observed with her hair hanging out the lower edge of her hairnet all around her head.</p> <p>At 11:52 A.M., Employee # 6. was observed serving a lunch plate and a</p> | | | |

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| | <p>bowl of plums to a resident with her thumb on the inside edge of the plate and bowl.</p> <p>At 11:55 A.M., Employee #7 was observed serving a bowl of plums to a resident with her open palm over the food. She placed the bowl on the table then picked the bowl back up and then served it to another resident at a different table.</p> <p>At 12:00 P.M., Employee #6 was observed serving a lunch plate and a bowl of plums to a resident with her thumb on the inside edge of the plate and bowl.</p> <p>At 12:01 P.M., Employee #8 was observed in the kitchen pick up a turkey sandwich with his ungloved left hand and place it on a plate. Employee #6 then served it to a resident.</p> <p>At 12:04 P.M., Employee #6 was observed to serve a lunch plate and a bowl of plums to a resident with her thumb on the inside edge of the plate and bowl.</p> <p>At 12:06 P.M., Employee #7 was observed while serving lunch pates in the dinning room with her hair hanging out the side of her hairnet.</p> | | | |

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| | <p>On 3/13/15 at 2:20 P.M., the ED (Executive Director) provided the current undated policy titled, "Personal Hygiene." The policy did not indicate how hairnets should be worn.</p> <p>During an interview on 3/13/15 at 2:21 P.M., the ED indicated the hairnets should cover all the hair when the staff is preparing or serving food...thumbs should not be in the plates...glasses and bowls should not be served with the hand over the top opening or thumbs on the inside rim.</p> <p>On 3/13/15 at 2:45 P.M., the ED provided the current undated policy titled, "Food Stock Rotation." The policy indicated "...5. Any item open must be dated with the opening date and wrapped airtight after opening...8... Any opened and not thawed box/bag will be dated and rewrapped before placing back in the freezer...."</p> <p>On 3/17/15 at 1:55 P.M., the ED provided the current undated policy titled, "Chemical Safety" provided by the ED indicated "...3. Chemicals will be stored away from food Storage rooms...."</p> <p>During an interview on 3/18/15 2:30</p> | | | |

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| F 441 SS=D Bldg. 00 | <p>P.M., the DON (Director of Nursing) indicated " ... we don't have a policy on food storage in the freezer..."</p> <p>During an interview on 3/19/15 at 10:06 A.M., the DM indicated "... thumbs can be on the inside of the rim of the plate... cups and glasses should be served with your hand on the lower half of the glass... bowls should be carried and served from underneath... at no time should be served with the fingers on the rim and open palm over the food... hairnets should cover all hair most of the time...when preparing foods gloves should be worn... at no time should food be handled with bare hands...."</p> <p>3.1-21 (I)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable</p> | | | |
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| | <p>environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to initiate a first step Mantoux testing within 48 hours of admission for 1 of 5 residents reviewed for Mantoux testing. (Resident #33)</p> <p>Finding includes:</p> | F 441 | 1. Resident # 33 had been admitted from a long term care facility and had not entered the community, A documented one step had been given in May 2014, resident 33 received her Mantoux per regulation. Evidence was not requested during the course of | 04/17/2015 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>On 3-18-2015 at 1:00 P.M., a record review of Resident #33 was conducted. An "Admission Assessment," dated 08/08/2014, indicated Resident #33 was admitted to the facility on 08/08/2014 at 6:00 P.M. An immunization record for a TB (tuberculin) 2 step Mantoux skin test for Resident #33 indicated the test was administered on 8/11/2014 at 1:00 P.M.</p> <p>On 3-18-2015 at 1:33 P.M., the current "Mantoux/TB Testing For Resident/Employee Policy," last updated 1/15, received from the Director of Nursing at this time, indicated, "...Resident Protocol:...2. If resident does not have documentation of a one or two step Mantoux within the twelve months prior to admission, a two-step must be initiated, with the first step being administered within 48 hours of admission...." An interview at this time with the Director of Nursing indicated, "...I am not sure why that wasn't done on time...."</p> <p>3.1-18(f)</p> | | <p>the survey. Residents admitted to the facility will have their Mantoux's performed in accordance with the regulation.</p> <p>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. The facility completed an audit on existing residents to ensure no other residents lacked a current Mantoux skin test.</p> <p>3. The nursing department has been educated on the Mantoux Policy and the state requirement by 4/17/15. The Nursing Administration team will review Immunization records that include Mantoux skin testing to ensure Mantoux skin testing are documented according to the regulation.</p> <p>4. The Director of Nursing and/or designee will review Immunization records twice a week on new admits for the first 6 weeks and then monthly, this will be forwarded to the QA&A committee for review, These audits will be reported monthly for a period of 6-months until compliance is achieved.</p> <p>5. Date of compliance 4/17/15</p> | |

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| F 502 SS=D Bldg. 00 | <p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure a urinalysis with culture and sensitivity was obtained in a timely manner for 1 of 3 residents reviewed for urinary (Foley) catheter use. (Resident #186).</p> <p>Finding includes:</p> <p>On 3/19/2015 at 9:30 A.M., the clinical record for Resident #186 was conducted. The MDS (Minimum Data Set) assessment indicated Resident #186 had a BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment, and participated in her care planning.</p> <p>The nurse's progress note, dated 3/16/2015 at 3:35 P.M., indicated Resident #186 had voiced a desire to try to discontinue her FC (Foley catheter).</p> <p>The physician's progress note, dated 3/16/2015 at 3:45 P.M., indicated "...UA C&S [urinalysis, culture and sensitivity test] today 3/16/2015 if no UTI [urinary tract infection], D/C [discontinue Foley] and start bladder training...." There was</p> | F 502 | <p>F-5021. Resident # 186 had the UA test completed as ordered on 3/19/15 there were no abnormal findings. . 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. · Residents that obtain UA orders from the primary care physician will be collected and performed as stated in the Lab monitoring protocol. . 3. The Nursing department have been educated on the policy as it relates to the regulation and policy on Timely Labs by 4/17/15. · The Nursing Administration team will perform Lab tracking audits daily to ensure no Labs were missed. 4. The Director of Nursing and/or Designee will perform Lab Audits twice a week for 6 weeks and then monthly thereafter. Results of those audits will be forwarded to QA&A monthly for 6-months and quarterly thereafter until compliance is achieved. 5. Date of Compliance: 4/17/15</p> | 04/17/2015 |

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| | <p>no documentation on the record to indicate this test had been completed on 3/16/15.</p> <p>During an interview on 3/19/2015 at 10:45 A.M., Resident #186 indicated on 3/16/2015 she requested her catheter be discontinued. She indicated on 3/19/2015 around 2:00 A.M. the staff collected a urine sample from her catheter bag to send for testing.</p> <p>During an interview on 3/19/2015 at 12:00 P.M., the DON (Director of Nursing) indicated the facility would run the lab report every morning to review the orders from the previous day. The DON indicated the facility did not run a lab reports on the mornings of 3/17/2015 and 3/18/2015, and she was not sure why it was not done.</p> <p>On 3/19/2015 at 12:00 P.M. the current protocol titled, Lab Monitoring Protocol, revised 12/13, provided by the DON (Director of Nursing) was reviewed. The Lab Monitoring Protocol indicated the following: "...A lab calendar or draw list will be run at the beginning of each day, reviewed for accuracy, and provided to the lab technician by nursing...The facility designee should audit all new admissions and all new lab orders within 24 hours or as soon as practicable."</p> | | | |

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| R 000 Bldg. 00 | 3.1-49(a) Sprenger Health Care was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. | R 000 | | | |