

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155804	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2013
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NAME OF PROVIDER OR SUPPLIER SPRENGER HEALTH CARE OF MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 60257 BODNAR BLVD MISHAWAKA, IN 46544
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F000000	<p>This visit was for the Investigation of Complaint #IN00132313.</p> <p>Complaint #IN00132313 - Substantiated - Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey Dates: August 28, and 29, 2013</p> <p>Facility Number: 013017 Provider Number: 155804 AIM Number: n/a</p> <p>Survey Team: Debora Kammeyer, RN-TL Julie Wagoner, RN Sharon Ewing, RN (8/29/13)</p> <p>Census Payor Type: Medicare: 16 Medicaid: 0 Private: 6 Other: 9 Total: 31</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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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	Quality Review completed on August 30, 2013, by Brenda Meredith, R.N.			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to ensure fall prevention interventions were in place for 1 of 4 residents reviewed for falls in a sample of 5. (Resident D)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 08/28/13 between 10:15 A.M. - 11:00 A.M., the Director of Nursing indicated Resident #D was confused, had recently fallen and/or had "crawled on the floor" and had alarms in use.</p> <p>The clinical record for Resident D was reviewed on 08/28/13 at 2:00 P.M. Resident #D was admitted to the facility on 03/08/13 with diagnoses, including but not limited to, muscular weakness, debility, chronic pain, breast cancer, hypertension, hypothyroidism, and urinary incontinence.</p> <p>The most recent Minimum Data Set</p>	F000323	F 323 Plan Of Correction In Accordance with tag F 323, section 4830.25 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES related to the allegation that the facility failed to ensure that fall prevention interventions were in place for resident D. Facility will ensure that fall interventions are in place for resident D. The facility will obtain compliance through education of staff to be checking fall interventions when entering and prior to leaving residents rooms. Re education will be provided by the Director of Nursing and or designee. Compliance will be monitored through use of random audits by the Director of Nursing and or designee of resident D and any other resident at risk. Random audits with be completed 4 times a week for the first 4 weeks and randomly thereafter. Inserviceing will be completed by September 19, 2013 and compliance achieved by Septmber 20, 2013.	09/20/2013			

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	<p>(MDS) assessment for Resident D, completed on 06/15/13, indicated the resident required extensive staff assistance for transferring and ambulating needs, and was moderately cognitively impaired.</p> <p>The health care plan for Resident D regarding falls, current through 10/18/13, indicated the plan was initiated on 03/08/13. The interventions included the following: "Assist in positioning for comfort as needed. Anticipate needs as able. Check sensor alarm functioning q [every] shift, electric hi/low bed in low position while bed occupied, encourage non-skid footwear at all times, encourage to ask/use call light for assistance. Call light within reach, Encourage/offer reminders to call/ask for assistance, ...Padded mat on floor next to bed at all times while resident is in bed. Sensor pad alarm to bed and chair. Alternate sensor pad between wheelchair and recliner."</p> <p>Review of Fall incident investigation reports for Resident, provided by the Director of Nursing, on 08/29/13 at 9:00 A.M., indicated the resident had fallen out of her bed or wheelchair on 03/18/13, 04/30/13, 05/17/13, 05/23/13, 06/02/13 three times, 06/06/13, 06/20/13 and 08/01/13.</p>			

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	<p>Resident D was observed, on 08/29/13 at 10:37 A.M., lying in her bed asleep. There was an overbed table beside her bed and a bed alarm box was noted flashing underneath her bed. There was a gray colored mat folded up and lying against the wall between the heating unit and the wardrobe. Interview with RN #8, who looked at a nursing assistant assignment sheet for Resident D indicated the gray mat should have been beside the resident's bed.</p> <p>This federal tag relates to Complaint #IN00132313.</p> <p>3.1-45(a)(2)</p>			