STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155804		04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRENGER HEALTH CARE OF MISHAWAKA	60257 BODNAR BLVD MISHAWAKA, IN 46544

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaints IN00196443, IN00196327 and IN00194735. Complaint IN00196443 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00196327 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Complaint IN00194735 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: April 14, 15, 18, 19, 20 and 21, 2016 Facility number: 013017 Provider number: 155804 AIM number: 201237680 Census bed type: SNF: 37 SNF/NF: 17 Residential: 30 Total: 84	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Census payor type: Medicare: 17 Medicaid: 14 Other: 23 Total: 54 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 14454 on April 28, 2016.			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the			

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	resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure a care plan was developed related to the use of anti anxiety medications for 1 of 19 residents reviewed for care plans. (Resident #95) Finding includes: On 4-18-16 at 1:14 P.M., the clinical record review was conducted for Resident #95. Resident #95 was readmitted to the facility on 1-18-16. A Physician's order, dated 2-12-16, indicated "...Lorazepam 0.5 mg Q [every] 4 hours as needed for anxiety...." Resident #95's care plans indicated there was not one developed for the diagnosis of anxiety or for the use of anti anxiety medications. During an interview on 4-19-16 at 10:35 A.M., the DON (Director of Nursing) indicated "...MDS [Minimum Data Set, assessment] nurse develops care plans...we have our utilization review meetings every Wednesday and review new medications for residents...care plans are then created or updated for new medications and diagnosis...." During an interview on 4-19-16 at 10:56	F 0279	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 such character as to limit our capacity to render adequate care as prescribed by regulation. This plan ofcorrection 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 POC F- 279 In accordance with F279, section483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS related to theallegation	05/17/2016

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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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	A.M., the Corporate MDS nurse indicated "...if a resident is on Ativan for anxiety they should have a care plan for it...." On 4-19-16 at 11:05 A.M., the Corporate MDS Nurse provided the current policy titled "Interdisciplinary Care Plan Process," last updated 10-29-13. The policy indicated "...care plans are to be updated and reviewed on an ongoing basis...when updating, review all physicians orders...." 3.1-35(a)		that the facility failed to ensure a care plan was developed relatedto the use of anti anxiety medications for resident #95. Care plan was updatedfor resident #95. An audit was completed on all residents that were orderedanti anxiety medication to ensure that their plan of care reflected theuse/need for anti anxiety medications. The MDS Coordinator was educated by theDON or designee on the need to review new orders daily and adjust the care planas needed for new physicians orders. Education will be completed by 5/16/2016with date of alleged compliance achieved by 5/17/2016. DON or designee willaudit residents with anti anxiety medications to ensure that they have a careplan that addresses to use of anti anxiety medications. Audits will becompleted 2 times a week for the first 6 weeksand then monthly thereafter for total of 6 months. Results of those audits willbe forwarded to QA&A monthly for 6-months and quarterly thereafter untilcompliance achieved.	
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview,	F 0282	F-282 In accordance with F282,	05/17/2016

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	the facility failed to follow a physician's order for daily weights, for 1 of 1 residents reviewed for dialysis. (Resident #113) Finding includes: On 4-20-2016 at 10:30 A.M., the clinical record for Resident #113 was reviewed. The MDS (Minimum Data Set) Admission Assessment, dated 3-1-2016, indicated the resident's diagnoses included but were not limited to, end stage renal disease, chronic obstructive pulmonary disease, hypertension, and respiratory disease. The current physician's orders included but were not limited to, dialysis on Mondays, Wednesdays, and Fridays, beginning on 3-14-2016, and daily weights, beginning on 4-1-2016. On 4-21-2016 at 8:45 A.M., the document entitled, "Sprenger of Mishawaka-SNF, Weights and Vital Summary," provided by the Administrator at that time, was reviewed. The document indicated the resident had not been weighed on April 3, 5, 6, 9, 17 and 18, 2016. Notations on the document indicated weights were not obtained on those dates for the following reasons:		section483.20(k)(3)(ii) SERVICE BY QUALIFIED PERSONS/PER CARE PLAN related to the allegation that the facility failed to follow a physician's order for daily weights on Resident #113. Resident #113 did not have a negative outcome related to the missed weights. During the survey the physician discontinued the order for daily weights. All residents in the facility that have daily weights ordered were reviewed for compliance. The DON or designee will provide education to all licensed nurses on the need to follow physicians orders for daily weights, and the entry of the results in the clinical record. Education will be completed by 5/16/2016 with the date of alleged compliance achieved by5/17/2016. The DON or designee will audit residents with ordered daily weights.Audits will be completed 3 times a week for the first 6 weeks and then monthly thereafter for total of 6 months. Results of those audits will be forwarded to QA monthly for 6-months and quarterly thereafter until compliance achieved.	

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	4-3-2016, "no explanation." 4-5-2016, "at hospital." 4-6-2016, "at dialysis." 4-9-2016, "no explanation." 4-17-2016, "at hospital." 4-18-2016, "at dialysis." The resident's MAR (Medical Administration Record) was reviewed, and indicated the resident went out to dialysis from the facility on April 1, 4, 6, 8, 11, 13,15, 18 and 20. The MAR also indicated the resident was not weight on dates that included but were not limited to, April 6 and 18. A progress note, dated 4-5-2016 at 1:52 P.M., indicated the following, "Resident complained of pain in left hip...resident requested to be sent to...ER [emergency room]...." The progress note indicated the resident would have been in the facility in the morning to obtain the physician ordered daily weight. During an interview on 4-21-2016 at 10:52 A.M., the DON (Director of Nursing) indicated Resident #113 should have had daily weights as ordered. She indicated when the resident went out to the hospital she should have been weighed in the morning, and the DON also indicated the resident should have been weighed in the mornings before			

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	going to dialysis. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure the plan of care was followed for a resident who required the use of a lumbar-sacral back brace for musculoskeletal support following a lumbar fusion (a surgery that is performed in an effort to relieve pain to the lower back). (Resident B) Finding includes: On 4/18/16 at 10:36 A.M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 5/15/16. The diagnoses included, but not limited to, spinal stenosis lumbar region, without neurogenic claudication, degenerative intervertebral disc site unspecified, aftercare follow surgery musculoskeletal system not elsewhere	F 0309	F-309 In accordance with F309, section483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING related to the allegation that the facility failed to ensure the plan of care was followed for Resident Bthat required the use of a lumbar-sacral back brace for muscle skeletal support.Resident B is no longer a resident at the facility. All residents with braces,splints, or immobilizers were reviewed to ensure that these devices were an active physicians order, the device is indicated on the care plan, and the device is triggered onto the Kardex to communicate the use to the direct care staff. DON or designee will complete the following education with the Licensed Nurses to review the noted devices require a	05/17/2016

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	classified, lumbago, difficulty in walking, muscle weakness generalized and generalized pain. A [name of local hospital] patient discharge instructions, dated 5/15/16, indicated LSO (lumbar-sacral orthoses) back brace and walker as equipment provided to the patient at discharge. A Occupational Therapy treatment encounter note dated 5/16/15, indicated "...Precautions: spinal brace on when sitting EOB [edge of bed] or when OOB [out of bed]...Evaluation: Physician's order received, Plan of Treatment developed on this date and initiated instruction/training in use of back brace when up in bed or in chair with CNA [Certified Nursing Assistant]...Skilled Instruction: Pt.[patient] and Caregiver Training: Instructed nursing caregivers in safety precautions specifically, use of back brace when sitting EOB or OOB in order to preserve current level of function and increase safety and reduce the risk of further medical complications that may result from impairments/conditions with 100 percent [sic] carryover demonstrated. Response to Tx [treatment]: Response to Session Interventions: observably less pain when seated up in chair...." The order summary report with the order		physicians order, if a resident refuses the device it should be documented as refused on the TAR, or documented in a nurses note, Care Plan and Kardex will reflect that physicians order. The DON or designee will educate the CNA's on utilization kardex to direct residents care as it relates to splints, braces, immobilizers. Education willbe completed by 5/16/2016 with the date of alleged compliance achieved by5/17/2016. The DON or designee will audit residents with splints, braces,immobilizers to ensure that there is a physicians order, the items use is indicated on the care plan, and the device is listed on the Kardex. Audits will be completed 3 times a week for the first 6 weeks and then monthly thereafter for total of 6 months. Results of those audits willbe forwarded to QA&A monthly for 6-months and quarterly thereafter until compliance achieved.	

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	date range of 5/1/15- 6/30/15, lacked documentation to indicate an order to ensure the back brace was placed when sitting at the edge of bed or out of bed. The resident's kardex (a document used by the facility to alert staff to indicate the care a resident is to receive) lacked any documentation of instruction to apply the back brace when out of bed or when sitting at the edge of bed. The nursing progress notes lacked documentation to indicate the resident refused the use of the back brace when not in therapy. On 4/21/16 at 10:08 A.M., an interview was conducted with the Director of Therapy. The Director of Therapy indicated general spinal precautions were no bending, lifting or twisting. The Director of Therapy indicated that Resident B would fling herself backward when she was feeling pain which was something that therapy was trying to avoid. She indicated the nursing department was informed of therapy observations. On 4/22/16 at 1:40 P.M., an interview was conducted with the Director of Nurses (DON). The DON indicated that she remembered Resident B but that she			

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	had not been a provider of care during that time nor was she in her role as DON at that time and could not comment on her specific instructions or precautions but that now since she has been in her position, you would expect to see all orders being placed into the system and reviewed each morning during the morning meeting. On 4/22/16 at 2:32 P.M., an interview was conducted with Licensed Practical Nurse (LPN) #40. LPN #40 indicated that she remembered Resident B and had provided care to Resident B. LPN #40 indicated that Resident B was non-compliant with wearing her back brace. When asked how a caregiver would know that Resident B would need a back brace LPN #40 indicated that when an order is received it is logged into the Medication Administration Record (MAR) or Treatment Administration Record (TAR) it is then talked about in report for the 1st week or so and the CNA's would be trained by therapy on how to apply it, any non compliance would be noted in the nurses notes. LPN #40 then reviewed the MAR and TAR of Resident B and indicated there was no order to indicate a back brace was to be worn by Resident B. On 4/22/16 at 3:30 P.M. an interview was			

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	conducted with the Director of Therapy Services. The Director of Therapy indicated instruction was given to the CNA who was working at the time but that the specific instruction or attendance of who was instructed on the back brace was not documented. This Federal Tag relates to Complaint IN00196327. 3.1-37(a)			
F 0364 SS=D Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food that was prepared conserved the nutritive value related to pureed food preparation related to 1 of 1 meals prepared. Finding includes: On 4-14-16 between 11:05 A.M. and 11:20 A.M., during puree meal preparation the following was observed:	F 0364	F-364 In accordance with F364, section483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP related to the allegation that the facility failed to ensure food was prepared conserved the nutritive value related to pureed food preparation. Dietary manager provided education to Cook # 5 in addition to all of the cooks related to the review and location of the pureed food recipes. Education will be completed by 5/16/2016 with the date of alleged compliance achieved by	05/17/2016

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	Cook #5, with gloved hands, added three ladles of soup (beef barley) in to the puree bowl then reached into a bag of crushed crackers, pulled out a handful of crackers, added it to the soup in the puree bowl, mixed it, removed his gloves, lifted the lid on the trash can, threw the gloves away, rinsed his hands off, put on new gloves, poured the puree into a pan and placed it on the steam table. With the same gloves, Cook #5 then placed one hamburger patty, one bun, into the puree bowl, then reached in the line cooler and removed the Swiss cheese, he then placed one slice of Swiss cheese and a unmeasured amount of hamburger juice into the puree bowl, mixed it, reached into a drawer removed a spoon, then scraped the puree it into a pan. Employee # 5 then looked through the daily menu with his gloved hands, then place 1/2 cup of cole slaw and a unmeasured amount of milk into the puree bowl, mixed it, then added 3 pumps of simply thick, hand stirred it into the coleslaw mixture then poured it into a bowl and then took off his gloves. During an interview on 4-20-16 at 1:24 P.M., the Corporate Dietary Manager indicated "... we have recipes for all our puree meals...the cooks should use them...."		5/17/2016. The Dietary manager or designee will audit pureed food preparation 3 times a week for the first 6 weeks and then monthly thereafter for total of 6 months. Audits and observations will be completed to ensure that the pureed food recipes are being followed as indicated. Results of those audits will be forwarded to QA&A monthly for 6-months and quarterly there after until compliance achieved.	

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	On 4-20-16 at 3:30 P.M., the Corporate Dietary Manager provided the current puree recipes for soup- beef barley, cheeseburger and cole slaw. The recipes indicated, for cheeseburgers "...bread layer: 1. Place required servings of buns to be pureed in food processor and process until fine consistency. 2. Gradually add hot broth to buns while processing...hamburger layer: 1... remove portions required...2. add to food processor and process until fine in consistency...3. Add hot broth... and a food thickener... serve...2. Top pureed bread with a #10 scoop pureed hamburger and 1 melted slice of cheese..." For creamy cole slaw "... creamy coleslaw ...food thickener... 2. remove portions to be pureed from the regular prepared recipe. 3. Add to food processor and process until fine consistency. 4. Add a food thickener to salad while processing. 5. Scrape down sides of processor with a rubber spatula and process for 30 seconds...." During an interview on 4-21-16 at 10:21 A.M., the Corporate Dietary Manager indicated we do not have a policy on pureed meals...we just follow the recipe...." 3.1-21(a)(1)			

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F 0371 SS=F Bldg. 00	483.35(i) 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 use of hairnets, handwashing, food temperatures, plates and food storage. From 1 of 1 Kitchens. Findings include: On 4-14-16 between 10:35 A.M. and 11:05 A.M., during the initial kitchen tour with Dietary Aide #2, the following was observed. On a clean dish rack: 30 food plate covers and bottoms were stored upright on clean rack by the three compartment sink. In the baking area: A scoop in the bulk sugar container, Dietary Aide #2 indicated at this time "...no it should not be kept in there...." On the clean pan rack:	F 0371	F-371 In accordance with F371, section483.35(i) FOOD PROCEDURE, STORE/PREPARE/SERVE – SANITARY related to the allegation that the facility failed to ensure meals were being served under sanitary conditions in regards to proper use of hairnets, handwashing, food temperatures, plates and food storage. The 30 food plate covers and bottoms were washed and stored downward, bulk sugar container was discarded and replaced with a new one, scoop stored appropriately with replacement, sauce pan was cleaned and then stored upside down, container of lettuce was discarded,the 3 bags or tortellini and pan of frozen chicken were discarded from the freezer, the 3 packages of hamburger meat were discarded, the 2 packages of thawed meat were discarded, lemon drink base was discarded, dented can of pickled beets was discarded, the 3 red sanitizer buckets were adjusted to appropriate sanitation levels, and dietary aide #3 was provided a hair net.Cook #5 had all concerns identified addressed	05/17/2016

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	A sauce pan , stored on it's side , Dietary Aide #2 indicated at this time "...no it should be stored upside down...." In the line cooler A container of lettuce uncovered and undated. In the walk in freezer: 3 bags of tortellini, open to air. A pan of frozen chicken on the rack open to air. Dietary Aide #2 indicated at this time "... yes they should be closed...." In the walk in cooler : 3-10 pound packages of hamburger with a label "use or freeze by 4/12/16" Dietary Aide #2 indicated at this time "...it is fresh hamburger not from the freezer...." 2-5 pound packages of, undated, thawed meat. Dietary Aide #2 indicated at this time "... yes it should have a use by date or a pulled date on it...." A container of lemon drink base, dated 4/4/16. In the dry storage: A 6 pound can of pickled sliced beets on the shelf with a dent on the bottom seam. A 6 pound can of three bean salad on the		and educated by the corporate dietician following the identification from the state surveyor. Dietary manager or designee to provide education to all dietary staff on storage, sanitation education. The education will include handwashing, glove use and removal,washing of raw food, food storage, dating items, storage of clean pans and dishes, hairnets, test holding temperatures, and thermometer protocol.Education will be completed by 5/16/2016 with the date of alleged compliance achieved by 5/17/2016. The Dietary manager or designee will complete a full sanitation audit and test tray temp audits. Audits will be completed 2 times a week for the first 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 achieved.	

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	shelf with a dent in the side. On the three compartment sink: 3 red buckets of sanitizer water that when tested, tested at 0 PPM (parts per million). Dietary Aide #3 observed walking through the kitchen from the back door to the front door with out a hairnet on. At 11:05 A.M., Cook #5, was observed, with gloved hands, adding three ladles of soup in to the puree bowl then reached into a bag of crushed crackers, with the same gloved hands, pulled out a handful of crackers, added it to the soup in the puree bowl, mixed it,removed his gloves, lifted the lid on the trash can, threw the gloves away, rinsed his hands off, put on new gloves, poured the puree into a pan and placed it on the steam table. With the same gloves, Cook #5 then placed one hamburger patty,one bun, into the puree bowl, then reached in the line cooler and removed the Swiss cheese, he then placed one slice of Swiss cheese and a unmeasured amount of hamburger juice into the puree bowl, mixed it, reached into a drawer removed a spoon, then scraped the puree it into a pan. Employee # 5 then looked through the daily menu with his gloved hands, then placed 1/2 cup of cole slaw and a unmeasured			

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	amount of milk into the puree bowl, mixed it, then added 3 pumps of simply thick, hand stirred it into the coleslaw mixture then poured it into a bowl and then took off his gloves. At 11:18 A.M., Dietary Aide #3 observed wearing her hairnet halfway up the back of her head, leaving loose hair hanging down in back . At 11:19 A.M., Dietary Aide #2 observed with long curls hanging out of the back of her hairnet. At 11:20 A.M., Cook #5 was observed to put gloves on without washing his hands, tempted the lunch food, took off gloves, lifted the trash can lid, threw the gloves away, then tempted the cole slaw. At 11:25 A.M., Cook #5 was observed to wipe off the food thermometer probe, lift the lid of the trash can, threw away the probe wipe, then tempted the pears. At 11:30 A.M., the following was observed while Cook #5 tempted the food on the salad bar: Cook #5 tempted the tomatoes at 49 degrees wiped of the thermometer probe, he then tempted the shredded cheese at 49.1 degrees, without wiping off the			

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	thermometer probe, tempted the lettuce, which tempted at 46.2 degrees. Cook # 5 then, without wiping off the thermometer probe, tempted the diced ham, which tempted at 45.2 degrees, Cook #5 then tempted the chopped turkey at 46.2 degrees. Cook #5 indicated at this time "...did not know what temperature the food should be held at...." At 11:45 A.M., Cook #5 was observed lift the trash can lid, threw away used gloves, then plated a lunch order. At 11:46 A.M., Cook #6 was observed, removing fresh tomatoes from the cooler, cut up them up and place them in a container for the salad bar without washing them. At 11:52 A.M., CNA #6 was observed in the kitchen with no hair or beard net on. During an interview on 4-20-16 at 1:24 P.M., the Corporate Dietary Manager indicated "... the plate covers and pans should be stored upside down... we don't use dented cans... the sanitizer buckets should test between 150 - 400 ppm [parts per million] ... food should be covered...we expect everyone in the kitchen to have a hairnet on with all the hair under the hairnet... if the beard is over 1 inch long they should have a beard			

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	net on...only dietary staff is allowed in the kitchen... cold foods that are holding should be at 41 degrees or less... we expect gloves to be worn when handling ready to eat foods....they should be changed and hands washed every time they change tasks or gloves get soiled... hands should be washed after touching trash cans and before putting on new gloves...they should not have been touching the menus when preparing the puree...vegetables should washed before cutting...." On 4-21-16 at 8:30 A.M., review of the current, undated policies "...Cooking, Holding, Cooling and Storing Potentially Hazardous Foods, Food Temperatures on Trayline, Washing Fruits and Vegetables, Dietary Handwashing, Date Marking of Food, Plastic Gloves, Hair Restraints, received from the Corporate Dietary Manager on 4-20-16 at 3:30 P.M., indicated "... Holding...2. Hold cold foods at 41 degrees F (Fahrenheit) or below... Prepare cold/hot foods: 1. Pre-chill ingredients for foods served cold [sandwiches and salads] to below 41 degrees F or below...Take Temperatures:...1. Wipe the thermometer stem with alcohol wipes prior to [let air dry] and after taking the temperature of each food... 4. Wash fresh produce vigorously under cold running water...2.			

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	Hands should be washed: ...c. Before serving food...G. Whenever changing gloves...J. Prior to starting trayline... All potentially hazardous food and ready to eat foods will be clearly marked to indicate the date by which the food must be discarded if not served... Hands are to be washed when entering the Dietary Department and before putting on the plastic gloves... Remember gloves are just like hands they get soiled. Anytime a contaminated surface is touched, the gloves must be changed...2. Handle the garbage or garbage cans...Hair...you must wear a protective hairnet in the production area. There must be no exposed or loose hair protruding from under the hairnet...men with mustaches or beards >1" must cover them fully with a beard net.... On 4-21-16 at 9:00 A.M., review of the current, undated, policy "Sanitation and Food Handling", received from the Administrator at this time, indicated "...4... when not in use cloths will soak in an appropriate sanitizing solution...Dented cans will not be used if dented as per policy. 1. When a dented can is found it will be removed from use and discarded or placed in the dented can area...." 3.1-21(i)(2)			

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F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall	F 9999	F-9999 In accordance with FINALOBSERVATIONS 3.1-14 PERSONNEL the state rule was not met related to theallegation that the facility failed to ensure that the two step mantoux methodwas followed by TB testing for RN#11, CNA#12, Dietary Aide #13, LPN#15, CNA#16and Cook #17. A two step mantoux was re-started for RN#11, CNA#12, Dietary Aide#13, LPN#15, CNA#16 and Cook #17. The facility completed an audit to identifyany other staff that did not have a full two step mantoux completed. Thosestaff had a two step restarted. All staff will have a 2 step mantoux in place.Going forward all staff will be screened for TB with a two step mantoux uponhire and a one step annual therafter. DON or designee with educate the nursemanagers on the staff mantoux policy. Education will be completed by 5/16/2016 with the date of allegedcompliance achieved by 5/17/2016. The DON or designee will audit mantouxcompletion via audits. Audits will be completed 3 times a	05/17/2016

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	be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure the two step Mantoux method was followed for TB (tuberculin) testing for 6 of 10 employee records reviewed. (RN #11, CNA #12, Dietary Aide #13, LPN #15, CNA #16 and Cook #17) Finding includes: On 4-20-16 at 1:00 P.M., review of the employment files for RN (Registered Nurse) #11 (hire date 3-16-16), CNA (Certified Nursing Assistant) #12 (hire date 3-2-16), Dietary Aide #13 (hire 1-27-16), LPN (Licensed Practical Nurse) #15 (hire date 11-19-15), CNA #16 (hire date 12-23-15) and Cook #17 (hire date 4-6-16) were reviewed. These files showed no documentation of a second step TB test being completed.		week for the first 6 weeks and then monthly thereafter for totalof 6 months. Results of those audits will be forwarded to QA&A monthly for6-months and quarterly thereafter until compliance achieved.	

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	On 4-20-16 at 1:28 P.M., during an interview, the DON (Director of Nursing) indicated they do the 2 step TB testing process and the second step is completed 1 to 3 weeks after the first step is completed. On 4-21-16 at 8:52 A.M., review of the current "Mantoux/TB testing for Resident/Employee Policy", last updated 2/09, received from the Administrator at this time, indicated "...Any employee without documented history of non-reactive PPD [protein purified derivative, TB test] within twelve months of hire will receive a two-step Mantoux. The second step will be performed within 7-10 days after initiation of the first step...." 3.1-14(t)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 30	R 0000		

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	Sample: 7 These deficiencies are cited in accordance with 410 IAC 16.2-5.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which			

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	they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure at least one staff person had current first aid training on the night shift for the week of April 11 to April 17, 2016. Finding includes: On 4/21/16 at 3:00 P.M., staffing records for the week of April 11 to April 17, 2016 were compared to Assisted Living Staff, CPR (Cardio Pulmonary Resuscitation) and first aid training certificates. The night shift on April 16 and 17, 2016 lacked documentation assigned staff had first aid training. The certification for Employee #61, who worked both night shifts, indicated this staff person had CPR and AED (Automated External Defibrillator) training. First aid training was not noted on the certification. During an interview on 4/21/16 at 3:15 P.M., Employee #62 indicated she thought the CPR training included the first aid training.	R 0117	This plan of correction is prepared and executed because itis required by the provisions of the state and federal regulations and notbecause 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 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	05/17/2016

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			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 POCThe Assisted Living manager was educated on R0117 and the requirements of first aide training by the Director of Nursing on 5/6/16. All assisted living staff files will be reviewed to ensure first aide training is current. This audit will be completed by the DON/designee by 5/17/2016 The DON/designee will monitor all new hires and current staff for compliance 2x/week for 6 weeks then periodically thereafter for 6 months to ensure compliance. The findings and results will be	

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			forwarded to QA monthly for 6 months and periodically thereafter until compliance is achieved.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure 4 of 7 records review had an annual health statement which included the resident was free of a disease in an infectious stage. (Residents #2, #3, #4 and #5) Findings include: 1. The clinical record for Resident #2 was reviewed on 4/21/16 at 10:52 A.M. Resident #2 was admitted on 12/24/13. The diagnoses included, but were not limited to: atril fibrillation, edema, cataract, transient ischemic attack, hypertension and pain. An annual health statement was not located in the medical record for Resident #2. 2. The clinical record for Resident #3 was reviewed on 4/19/16 at 2:00 P.M.	R 0409	R-409 In accordance with R409, section410 IAC 16.2-5-12(d) Infection Control – Noncompliance related to the allegation that the facility failed to ensure that all residents residing in the residential facility received an annual health statement which included the resident was free of a disease in an infectious stage. This affected Residents#2, #3, #4, and #5. Residents #2, #3, #4, and #5 will have an annual health assessment completed by the attending physician by 5/16/2016. The assisted living manager was educated on the need to obtain annual health statements on all residents residing in the assisted living. Education was provided by the DON on 5/6/2016 with date of alleged compliance achieved by 5/17/2016. The DON or designee will complete audits on annual assessments once a week for the first 6 weeks and then monthly thereafter for a total of 6 months.	05/17/2016

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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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	Resident #3 was admitted to the facility on 1/13/15. The diagnoses included, but were not limited to: spinal stenosis, cardiac pacemaker, osteoporosis and pressure ulcer on ankle and heel. An annual health statement was not located in the medical record for Resident #3. 3. The clinical record for Resident #4 was reviewed on 4/19/16 at 2:30 P.M. Resident #4 was admitted on 9/17/14. The diagnoses included, but were not limited to: depression, arthritis, hypertension, edema and diabetes. An annual health statement was not located in the medical record for Resident #4. 4. The clinical record for Resident #5 was reviewed on 4/20/16 at 10:13 A.M. Resident #5 was admitted on 3/1/15. The diagnoses included, but were not limited to: stage 3 chronic kidney disease, osteoporosis, hypertension and hypothyroidism. An annual health statement was not located in the medical record for Resident #5. During an interview on 4/21/16 at 2:40		Results of those audits will be forwarded to QA&A monthly for 6 months and quarterly thereafter until compliance is achieved.	

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 04/21/2016
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	P.M., Employee #60 indicated the annual health statement had not been completed for the residents.			