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 02/07/2014

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
F000000	This visit was for an Recertification and State Licensure Survey. Survey dates: February 3, 4, 6, & 7, 2014. Facility number: 013017 Provider number: 155804 AIM number: N/A Survey team: Julie Baumgartner, RN-TL Shauna Carlson, RN (2/03, 2/04, 2014) Sharon Ewing, RN Shelly Miller-Vice, RN (2/04, 2/06, 2/07, 2014) Honey Kuhn, RN (2/06, 2/07, 2014) Census bed types: SNF: 38 Residential: 08 Total: 46 Census payor type: Medicare: 14 Other: 32 Total: 46 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F000000		

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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	Quality Review completed on February 14, 2014, by Brenda Meredith, R.N.			

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F000441 SS=E	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 environment and to help prevent the development and transmission of disease and infection. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, record reviews and interviews, the facility	F000441	F441In accordance with tag F441, section 483.65,	03/06/2014

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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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	did not provide direction for communicating isolation precautions prior to entering the isolation room's of 2 of 2 Resident's. (Resident's #125 and #137) Finding includes: On 2/4/14 at 11:50 a.m., an observation was conducted of the 100 hall. Resident #125 and Resident #137 were noted to be in an isolation precaution indicated by a 3-drawer plastic wheeled cart stocked with Personal Protective Equipment (PPE) such as: yellow disposable gowns, disposable gloves and disposable face masks. Signs were not on the residents doors indicating others should notify the nurse prior to entering the room to support isolation precautions. On 2/4/14 at 11:52 a.m., an observation was made of the Activities Director entering Resident #125 without using the PPE. On 2/4/14 at 3:00 p.m., an interview was conducted with Staff #50, #52 and #53 indicating both Residents were in isolation and required using the PPE upon entry to the rooms of Resident #125 and #137.		INFECTION CONTROL, PREVENT SPREAD,LINENS related to the allegation that the facility did not provide direction for communicating isolation precautions prior to entering isolation rooms for resident #125 and #137. Residents #125 and #137 have since been discharged from the facility. The facility does not currently have any residents that require any isolation precautions. The facility will obtain compliance through utilization of new signs that will be used to indicate that a resident requires isolation precautions. The new signs will state "Attention: Please see the nurse prior to entering the residents room". Re-education will be provided to all staff, including the Activities Director, on the "Infection Control Policies, Transmission-Based Precautions". Activities Director and or designee will speak with the community volunteers as they sign in prior to visiting a care area. They will be educated on the signs that will be posted for residents that require precautions and the need to meet with the nurse prior to entering those rooms. The education will be tracked on a log kept by the Activities Director. This education and log will be on-going as new volunteers visit Sprenger Health Care of Mishwaka Care Center. Audits of residents that require Isolation Precautions will be	

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	On 2/4/14 at 3:30 p.m., an observation was made of a volunteer staff entering Resident #125 without using the PPE. There was no sign on the door acknowledging the isolation precautions. On 2/4/14 at 3:35 p.m., an interview was conducted with the volunteer staff entering Resident #125's room without using the PPE indicating no knowledge of having to use the PPE to visit with Resident #125 to administer communion and prayers. On 2/4/14 at 3:40 p.m., an interview was conducted with Resident #125 indicating the isolation precaution was due to, "... I have infections in my toes, MRSA (Methicillin resistant staphylococcus aureus, a bacterial infection) and I've been in this since I came from the hospital...." It was indicated, "... everyone that comes in here is suppose to gown up and put those masks over their faces...." On 2/4/14 at 3:45 p.m., a record review for Resident #125 was conducted. Resident #125 diagnosis , included but was not limited to, MRSA of the toes. The resident was on contact isolation precautions.		audited by the DON or designee 3 times a week for 6 weeks and once a week for 6 months. The results of audit tools will be reviewed by the Quality Assurance Committee monthly, adjustments and or recommendations will be made if compliance is not achieved. In servicing will be completed by March 5, 2014 and compliance achieved by March 6, 2014.	

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	On 2/4/14 at 3:45 p.m., a record review for Resident #137 was conducted. Resident #137's diagnosis included, but was not limited to, C-diff (Clostridium difficile, a bacterial infection). The resident was on antibiotic therapy treatment and contact isolation precautions. On 2/6/14 at 11:00 a.m., an observation was conducted of Resident #125 and #137's rooms indicating isolation precautions carts to be at their doorways and door knob hang tags on their doorknobs. The door knob signs stated, "Isolation Precautions." It was noted there were no directives indicated for utilizing the PPE at the doorways or to make contact with nursing services for further information before entering an isolation room. On 2/7/14 at 11:00 a.m., an interview was conducted with the Infection Control Nurse indicating that Resident #125 and #137 were both in contact isolation precautions and PPE were to be used upon entry to both rooms by all staff. On 2/7/14 at 2:00 p.m., a record review was conducted of the policy and procedures pertaining to the			

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	contact isolation precautions and the expectations of the staff, family, visitors and peripheral personnel. The following was provided for review: "Infection Control Policies. Infection control Surveillance Infection. Policy: ... Procedure:... 3. Isolation needs/patterns will be identified by the Infection control Nurse...A. The nurse obtaining the order for isolation for placing the sign on residents door and placing isolation chest for access to Personal Protective Equipment...." 3.1-18(b)(2)			
F009999	3.1-21 FOOD (i) The facility must do the following: (2) Comply with 410 IAC 7-20. This rule was not met evidenced by: Based on observations, interviews and record reviews, the facility failed to provide a policy and procedure for supervision of maintaining	F009999	F9999In accordance with F9999, FINAL OBSERVATIONS 3.1-21 FOOD and Compliance with 410 IAC 7-20 related to the allegation that the facility failed to provide a policy and procedure for supervision of maintaining temperature logs for the personal refrigerators in the Residents' rooms. Compliance will be achieved by education and training for the Housekeeping Supervisor by the Corporate	03/06/2014

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	temperature logs for the personal refrigerators in the Residents' rooms. This affected 35 of 35 residents personal refrigerators. Findings included: On 2/4/14 at 11:00 a.m., an observation was made of Resident #127's in room refrigerator indicating a template form titled,"Refrigerator Temperature Chart." This form supplied opportunity for monitoring the temperature maintenance of the personal refrigerators by the staff. It was observed to not be consistently completed. On 2/4/14 at 11:01 a.m., an interview was conducted with Resident #127 indicating the refrigerators were provided by the facility for the personal use of each resident and the maintenance was completed by the facility staff. On 2/4/14 at 11:45 a.m., an interview was conducted with the Director of Housekeeping indicating it was the responsibility of the Housekeeping staff to quality control the daily temperatures and complete the forms found on the side of each refrigerator. It was indicated that every resident was provided a		Director of Houskeeping and Laundry. Training of the Housekeeping Supervisor was completed on, February 21, 2014. Education will be provided to the Housekeeping staff on temp monitoring for the in room refrigerators with the updated policy titled, “Infection Control Policies, Refrigerator Cleaning and Disinfecting” Temperatures will be logged daily by the housekeeping staff. Audits will be completed by the Administrator or designee 4 days a week for the first 6 weeks, then 1 day a week for 6 months. The results of audit tools will be reviewed by the Quality Assurance Committee monthly, adjustments and or recommendations will be made if compliance is not achieved. In servicing will be completed by March 5th, 2014 and compliance achieved by March 6, 2014.	

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	personal in room refrigerator. On 2/6/14 at 1:55 p.m., an interview was conducted with the Infection control Nurse indicating the Policy and Procedure for maintaining the quality control of the resident in-room refrigerators was the responsibility of the Housekeeping Department. On 2/6/14 at 1:56 p.m., a record review was conducted of the Policy and Procedure titled," Infection Control Policies. Refrigerator Cleaning and Disinfecting. Policy.... Procedure....4. Housekeeping will monitor and log temps in resident rooms...." On 2/7/14 at 2:30 p.m., an interview was conducted with the Housekeeping Director indicating it was not supported by the specific job responsibilities and though it was provided, it was not sure to how or in what manner the job was to be consistently completed by her department,"... I didn't receive training for this form, I can't find it in the policy and procedures, I've just done what the other housekeepers have told me to do... I really can't tell you what is really suppose to be done with the temperature logging...			

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	we do it daily, and we use the form on the side of the refrigerators, but I've never been taught how the facility really wants this done... I'm sorry, that's just the truth... the Administrator (now, no longer at this facility) was showing me what to do, but I don't have like a job responsibility check off form... I was never given one... I've just followed what the other staff has told me to do... I know it's inconsistently done and the forms are not accurately up to date...." On 2/7/14 at 2:40 p.m., a record review was conducted of the personnel file of the Housekeeping Director to identify the training for Infection control and the guidelines for the Resident in room personal refrigerators. A program titled, "Housekeeping/Laundry Orientation Program," was conducted indicating a lack of direction for maintenance of the refrigerators. On 2/7/14 at 3:15 p.m., an interview was conducted with the Director of Human Resources indicating the file for the Housekeeper Director did not have a specific job responsibility acknowledgement, "...all I can say is the Administrator was doing her orientation and there is not a specific			

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	job responsibility form in her personnel file," in relationship to the resident in room refrigerator quality control. It was indicated that it was the housekeepers responsibility. On 2/7/14 at 3:30 p.m., an interview was conducted with the Quality Assurance Director of the facility's corporation indicating the facility had not assigned this responsibility and had not provided this in the specific job description for the Housekeeper upon hire and orientation. It was noted the form being used for quality control for accurate temperatures for Infection Control measures were not supported in the training, orientation or policy and procedure for the Housekeeper Director. 3.1-21(i)(2)			