PRINTED: 05/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
155804		B. WIN	B. WING			04/23/2020	
		<u> </u>					
NAME OF P	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
					BODNAR BLVD		
SPRENGER HEALTH CARE OF MISHAWAKA				MISHAV	WAKA, IN 46544		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for the	he Investigation of Complaint	F 00	00			
	IN00325155.						
	Complaint IN0032	5155 - Substantiated.					
	Federal/state defici	encies related to the					
	allegations are cited	d at F880.					
	Survey dates: April 22 and 23, 2020.						
	The state of the s						
	Facility number: 013017						
	Provider number: 155804						
	AIM number: 201237680						
	Census Bed Type:						
	SNF/NF: 23 SNF: 16 Total: 39						
	Census Payor Type	»:					
	Medicare: 16						
	Medicaid: 15						
	Other: 8						
	Total: 39						
	This deficiency ref	lects State Findings cited in					
	accordance with 41						
	Quality Review wa	s completed on May 1, 2020.					
	· •	•					
F 0880	483.80(a)(1)(2)(4))(e)(f)		ĺ			
SS=D	Infection Preventi						
Bldg. 00							
	The facility must establish and maintain an						
	-	on and control program					
	•	de a safe, sanitary and					
	comfortable environment and to help prevent						
the development and transmission of							
	•						

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

TITLE

(X6) DATE

Any defiency statement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7C7G11

Facility ID: 013017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED		
155804		155804	B. W	ING		04/23/	2020
		<u></u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					BODNAR BLVD		
CDDENICED LIEALTH CADE OF MICHAWAKA							
SPRENGER HEALTH CARE OF MISHAWAKA				MISHA	NAKA, IN 46544		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	communicable diseases and infections.						
	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to						
	* *	communicable diseases or they can spread to other					
	infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should						
	be reported;						
	(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and						
		that the isolation should be					
		e possible for the resident					
	under the circums	tances.					
					1		ı

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMI		COMPL	MPLETED	
155804		155804	B. WING 04/23/20			₂₀₂₀		
				CEDELE	ADDRESS OVEN STATE JID CODE			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
SPRENGER HEALTH CARE OF MISHAWAKA					BODNAR BLVD			
SPRENG	ER HEALTH CARE	E OF MISHAWAKA		MISHA	WAKA, IN 46544			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	(v) The circumstar	nces under which the						
	facility must prohil	bit employees with a						
	communicable dis	sease or infected skin						
	lesions from direc	t contact with residents or						
	their food, if direct	contact will transmit the						
	disease; and							
	(vi)The hand hygic	ene procedures to be						
	followed by staff in	nvolved in direct resident						
	contact.							
	§483.80(a)(4) A system for recording							
	incidents identified under the facility's IPCP							
	and the corrective actions taken by the							
	facility.							
	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.							
	§483.80(f) Annual							
	The facility will conduct an annual review of							
	·	ate their program, as						
	necessary.							
	Based on record review, and interview, the		F 08	380	This Plan of Correction is		04/27/2020	
	-	low CDC guidance related to			prepared and executed becau			
	-	of signs and symptoms of			is required by the provisions o			
	COVID-19. This deficient practice affected:				State and Federal Law and no			
	5 residents reviewe	d for infection tracking and			because Sprenger Health Care	e of		
	assessments.				Mishawaka agrees with the			
	Finding includes: During an interview, conducted with the Director of Nurses (DON), on 4/22/2020 at 2:00 P.M., the DON indicated COVID-19 respiratory screens were conducted daily for the residents of				allegations and citations listed			
					the Statement of Deficiencies.			
					Sprenger Health Care of			
					Mishawaka maintains that the			
					alleged deficiencies do not			
					jeopardize the health and safe	ty of		
					our residents, nor are they of			
	the facility as per g	uidance from the CDC.			such character so as to limit of	ur		
	1. The clinical record for Resident C was				capability to render adequate			
					care. Additionally, this Plan of			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155804	B. W	B. WING		04/23/2020	
1					-		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					BODNAR BLVD		
SPRENG	SER HEALTH CARE	E OF MISHAWAKA		MISHA	WAKA, IN 46544		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	BROWINEDS BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	16	DATE
	reviewed on 4/22/2	020. The clinical record			Correction is not meant to		
	lacked documentati	on of a covid respiratory			establish right to raise all poss	ible	
	screen was conduct	ed on 4/17/2020 and			contentions and defenses in a	ny	
	4/21/2020. Residen	t C was asymptomatic.			civil or criminal claim, action o	r	
					proceeding. This Plan of		
	2. The clinical reco	rd for Resident D was			Correction shall operate as		
	reviewed on 4/22/2	020. The clinical record			Sprenger Health Care of		
	lacked documentati	on of a covid respiratory			Mishawaka written credible		
	screen on 4/17/2020	0, 4/20/2020 and 4/21/2020.			allegation of compliance.		
	Resident D was asy	mptomatic.			In accordance with F880, Sec	tion	
					483.80 (a)(1)(2)(4)(e)(f), Infect	ion	
	3. The clinical reco	rd for Resident E was			Prevention & Control, related	to	
	reviewed on 4/22/2020. The clinical record				the allegation that the facility fa	ailed	
	lacked documentati	on of a covid respiratory			to ensure daily COVID		
	screen on 4/17/2020, 4/19/2020, 4/20/2020,				Respiratory Screens on all		
	and 4/21/2020. Resident E was asympomatic.				residents per policy. This affect	cted	
					Residents C, D, E, F and G ar	nd	
	4. The clinical record for Resident F was reviewed on 4/22/2020. The clinical record				there were no negative outcor	nes	
					as a result of this allegation. A		
	lacked documentati	on of a covid respiratory			Resident identifier has not		
	screen on 4/17/2020	0, 4/19/2020, and			provided on exit, therefore the		
	4/20/2020. Resident F was asympomatic.				facility cannot determine if any	or or	
					all residents still reside at the		
	5. The clinical reco	rd for Resident G was			facility.		
	reviewed on 4/22/2	020. The clinical record			Residents C, D, E, F and G		
	lacked documentation of a covid respiratory screen on 4/17/2020 and 4/21/2020. Resident G				experienced no changes to the	eir	
					clinical status and remain		
	was asymptomatic.				asymptomatic, at the time of the	ne	
	The CDC Long Term Care Infection Control				survey.		
					All current residents were aud	ited,	
	guidance Tool Kit provided to the facility on				by the DON/Designee on		
	March 27, 2020 indicated, "Nursing Home			4/23/2020, to ensure a COVID			
	Infection Prevention Assessment Tool for			Respiratory Screen was triggered			
	COVID-19Identify Infections Early: Actively			to be completed daily, per policy.			
	screen all residents at least daily for fever and				All Licensed Nurses were		
	respiratory symptoms, immediately isolate anyone who is symptomatic"				educated on the required daily	′	
					completion of the COVID		
					Respiratory Screen per facility	,	
	During an interview with the DON, on 4/23/2020				policy by the DON or designed	by	
	at 10:30 A.M., she indicated residents should				4/24/2020, with the date of alle	eged	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155804		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/23/2020		
NAME OF PROVIDER OR SUPPLIER SPRENGER HEALTH CARE OF MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 60257 BODNAR BLVD MISHAWAKA, IN 46544				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	have daily screenings for COVID-19 and she was in the process of reducating staff to the procedure. This Federal tag is related to Complaint IN00325155.				compliance of 4/27/2020. The facility conducted daily audits of all current residents, for the first weeks to ensure timely complet of COVID Screens. After the first weeks, the facility will conduct audits on 3-4 residents per day and then randomly thereafter for total of 4 months, to ensure compliance is maintained. Residents will be reviewed to the Quality Assurance Committee.	st 2 etion rst ct y, for a	

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