STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155804	A. BUILDING 00 B. WING	04/23/2020

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 the Investigation of Complaint IN00325155. Complaint IN00325155 - Substantiated. Federal/state deficiencies related to the allegations are cited at F880. Survey dates: April 22 and 23, 2020. 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 reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on May 1, 2020.	F 0000		
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide 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

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	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 identify possible communicable diseases or 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 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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	(v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved 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 review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on record review, and interview, the facility failed to follow CDC guidance related to timely assessment of signs and symptoms of COVID-19. This deficient practice affected 5 of 5 residents reviewed for infection tracking and assessments. 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 the facility as per guidance from the CDC. 1. The clinical record for Resident C was	F 0880	This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Sprenger Health Care of Mishawaka agrees with the allegations and citations listed on the Statement of Deficiencies. Sprenger Health Care of Mishawaka maintains that the alleged deficiencies do not jeopardize the health and safety of our residents, nor are they of such character so as to limit our capability to render adequate care. Additionally, this Plan of	04/27/2020

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	reviewed on 4/22/2020. The clinical record lacked documentation of a covid respiratory screen was conducted on 4/17/2020 and 4/21/2020. Resident C was asymptomatic. 2. The clinical record for Resident D was reviewed on 4/22/2020. The clinical record lacked documentation of a covid respiratory screen on 4/17/2020, 4/20/2020 and 4/21/2020. Resident D was asymptomatic. 3. The clinical record for Resident E was reviewed on 4/22/2020. The clinical record lacked documentation of a covid respiratory screen on 4/17/2020, 4/19/2020, 4/20/2020, and 4/21/2020. Resident E was asympomatic. 4. The clinical record for Resident F was reviewed on 4/22/2020. The clinical record lacked documentation of a covid respiratory screen on 4/17/2020, 4/19/2020, and 4/20/2020. Resident F was asympomatic. 5. The clinical record for Resident G was reviewed on 4/22/2020. The clinical record lacked documentation of a covid respiratory screen on 4/17/2020 and 4/21/2020. Resident G was asymptomatic. The CDC Long Term Care Infection Control guidance Tool Kit provided to the facility on March 27, 2020 indicated, "...Nursing Home Infection Prevention Assessment Tool for COVID-19...Identify Infections Early: Actively screen all residents at least daily for fever and respiratory symptoms, immediately isolate anyone who is symptomatic...." During an interview with the DON, on 4/23/2020 at 10:30 A.M., she indicated residents should		Correction is not meant to establish right to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. This Plan of Correction shall operate as Sprenger Health Care of Mishawaka written credible allegation of compliance. In accordance with F880, Section 483.80 (a)(1)(2)(4)(e)(f), Infection Prevention & Control, related to the allegation that the facility failed to ensure daily COVID Respiratory Screens on all residents per policy. This affected Residents C, D, E, F and G and there were no negative outcomes as a result of this allegation. A Resident identifier has not provided on exit, therefore the facility cannot determine if any or all residents still reside at the facility. Residents C, D, E, F and G experienced no changes to their clinical status and remain asymptomatic, at the time of the survey. All current residents were audited, by the DON/Designee on 4/23/2020, to ensure a COVID Respiratory Screen was triggered to be completed daily, per policy. All Licensed Nurses were educated on the required daily completion of the COVID Respiratory Screen per facility policy by the DON or designee by 4/24/2020, with the date of alleged	

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	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 2 weeks to ensure timely completion of COVID Screens. After the first 2 weeks, the facility will conduct audits on 3-4 residents per day, and then randomly thereafter for a total of 4 months, to ensure compliance is maintained. Results of the Audits will be reviewed by the Quality Assurance Committee.	