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	11/30/2021

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 IN00366902. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00362482 completed on 10/5/2021. Complaint IN00366902 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00362482 - Corrected. Unrelated tag is cited. Survey dates: November 29 & 30, 2021 Facility number: 013017 Provider number: 155804 AIM number: 201237680 Census Bed Type: SNF/NF: 24 SNF: 2 Residential: 24 Total: 50 Census Payor Type: Medicare: 2 Medicaid: 14 Other: 10 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/1/21.	F 0000		

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

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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 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;			

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	(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. (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, observation and interview, the facility failed to use appropriate infection control practices during wound care for 1 of 2 residents observed for wound care. (Resident B) Finding includes:	F 0880	It is the intent of Sprenger Healthcare to maintain infection prevention and infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable	12/10/2021

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	During an observation, on 11/30/2021 at 9:36 A.M., the ADON (Assistant Director of Nursing) removed a gauze wrap from Resident B's left lower leg/foot exposing 5 open areas. The ADON cleaned the first area to the right medial ankle with a wet gauze pad. She obtained a paper measuring tool, and held it against the open area while measuring the 1st wound. An area of blood, the size of a nickel was observed on the end of the measuring tool after measuring the wound. The ADON removed her gloves washed her hands and applied new gloves. She cleaned the 2nd area to the lower posterior ankle, and used the same paper measuring tool to measure the open area. The ADON removed her gloves washed her hands and applied new gloves. She cleaned the 3rd area to the left heel, and used the same paper measuring tool to measure the open area. The ADON removed her gloves washed her hands and applied new gloves. She cleaned the 4th area to the lateral foot, and used the same paper measuring tool to measure the open area. The ADON removed her gloves washed her hands and applied new gloves. She cleaned the 5th area to the left heel and used the same paper measuring tool to measure the open area. Continued observation, on 11/30/2021 at 10:15 A.M., RN 6 removed the gauze wrapping to Resident B's right leg and foot exposing an open area to the right plantar heel. The ADON, with the same gloved hands, cleaned the area with a wet gauze pad. She indicated the		diseases and infections. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident was assessed by the physician December 8, 2021, with no findings related to the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents receiving wound care were assessed by physician December 8, 2021. No concerns were noted. Licensed nursing staff were re-educated on the Guidelines for Measuring Wounds protocol by Regional QA Nurse/designee with return demonstration for measuring of wounds including the points which require hand washing and use of new measuring device for every wound. What measure will be put into place and what systemic changes will be made ensure that the deficient practice does not recur; The policy has been reviewed by QA committee and updated to include hand hygiene and changing of measuring tool has been added to the protocol. All staff received re-education on hand hygiene including return demonstration by Director of Nursing/designee. The License d staff received re-education on measuring of wounds and hand	

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	area was an old one, it was a stage II with eschar (dead skin) at the edge of the wound. The ADON used a paper measuring tool and measured the wound. She placed a new dressing on the wound and wrapped the leg with gauze kerlix. The ADON did not remove the dirty gloves or wash her hands after cleaning the dirty area and before applying the clean dressing. During an interview, on 11/30/2021 at 11:50 A.M., the ADON indicated she should not have used the same measuring tool to measure the areas and should have removed the dirty gloves and washed her hands before applying the new dressing. A policy was requested for Changing Wound Dressings, but one was not provided. On 11/30/2021 at 3:01 P.M., the Administrator provided the policy titled, "Handwashing", dated 11/18, and indicated the policy was the one currently use by the facility. The policy indicated"... Hands will be washed or decontaminated, using an approved alcohol-based hand sanitizer: 4. After handling contaminated items...." 3.1-18(b)(1) 3.1-18(l)		hygiene during wound care by the DON/designee. How will the corrective action be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place; Audits of hand hygiene will be conducted 5 random staff members weekly by Director of Nursing/designee. Audit of infection control for wound care practices and measurements will completed with 3 dressing changes weekly by Director of Nursing/designee. If any deficient practice is identified employee will be educated immediately following the deficient practice audits will be conducted a minimum of 6 months. Results of audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly until 6 months of compliance is accomplished, for a minimum of 6 months at 100% compliance reporting of the audits. The committee will then determine the need for monitoring.	