

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2014
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NAME OF PROVIDER OR SUPPLIER  IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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F000000	<p>This visit was for the Investigation of Complaint IN001587887 and IN00158429.</p> <p>Complaint IN00157887 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226.</p> <p>Complaint IN00158429 - Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: October 28, 29, 30 &amp; 31, 2014</p> <p>Facility number: 000042 Provider number: 155103 AIM number: 100291540</p> <p>Survey team: Diana McDonald, RN-TC Sharon Ewing, RN</p> <p>Census bed type: SNF/NF: 103 Total: 103</p> <p>Census payor type: Medicare: 10 Medicaid: 75 Other: 18 Total: 103</p>	F000000	<p>This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Ironwood Health and Rehabilitation Center requests consideration for a desk review of the plan of correction.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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F000225 SS=D	<p>Sample: 8</p> <p>The deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on November 7, 2014, by Brenda Meredith, R.N.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all</p>				

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	<p>alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse was immediately reported to the Indiana State Department of Health. This deficient practice affected 1 of 3 residents reviewed for abuse. (Resident F)</p> <p>Finding includes:</p> <p>On 10/29/14 at 4:00 P.M., an interview with CNA #1 was conducted. CNA #1 indicated about a month ago she was on her way to lunch when she witnessed Resident F with his hand touching Resident H, "...down there...." (CNA demonstrated rubbing to her upper thigh womanly area). CNA #1 indicated she stopped the incident and told CNA #2 about the incident and took Resident H to RN #3 for further evaluation. CNA #1 indicated she then went to lunch with CNA #2.</p>	F000225	<p><b>F225</b> It is the practice of this facility that all alleged violations involving mistreatment, neglect, or abuse and misappropriation of resident property are reported immediately to the Indiana State Department of Health. Corrective Action: Facility will follow Policy and Procedure related to Abuse Prohibition. How others identified: Residents residing in facility will be addressed by following policy and procedure and re-education and/or disciplinary action per policy of employees. Preventative Measures: Staff re-educated on reporting procedure related to Abuse Prohibition. Monitoring: Administrator and/or designee will continue to follow up on all allegation of abuse immediately. A grievance form and/or accident/incident will be completed on any allegation of abuse and will be followed up by Administrator and/or designee</p>	11/28/2014

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	<p>On 10/30/14 at 11:34 A.M., an interview was conducted with the Administrator of the facility. The Administrator indicated for the past year CNA #1 had been making false accusations against a nurse at the facility, LPN #6. She further indicated in August CNA #1 told CNA #2 that Resident F rubbed up on Resident H's leg. CNA #1 then proceeded to go to lunch and call and text team members of the facility and talked about the incident but had not reported it to the Director of Nurses. The Administrator further indicated CNA #1 was suspended and an investigation of the reported event was initiated. The Administrator indicated CNA #1 continued to blame LPN #6 for her suspension even though she had reported the incident to RN #3.</p> <p>On 10/30/14 at 11:40 P.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated the allegation was not reported. The Director of Nurses further indicated it (allegation) did not occur and was viewed to be another incident of false allegations made against LPN #6 by CNA #1.</p> <p>On 10/30/14 at 2:15 P.M., the Director of Nurses provided an investigation that was dated 8/24/14. Review of the investigation, at that time indicated the</p>		<p>immediately per policy. Grievance and accident /incident forms are reviewed daily during morning meeting. Monitoring will continue on an indefinite basis per policy. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.</p>	

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	<p>following, "... the security cameras show that no incident occurred as CNA #1 says it did...The male resident was pulling himself along the railing and stopped momentarily in front of the female resident doorway. No female resident was visible in the doorway, and the male resident reached out to push himself off the door frame, and then continued to pull himself along the railing down the hall. The c.n.a.[CNA #1] was still in the dining room approx. same time the male resident stopped momentarily at the door, and then came down the hall &amp; spoke to another c.n.a. in the hall and turned around and walked away. The other c.n.a. continued to walk down the hall. Neither c.n.a. spoke to the male or female resident in question...."</p> <p>On 10/30/14 at 2:30 P.M., a current policy, provided by the Director of Nurses and titled, "...Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property....Revised April 2013..." was reviewed. The policy indicated the following:"...Reporting...2. Report the incident immediately to the Administrator and DON/designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source, and</p>						

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F000226 SS=D	<p>misappropriation of resident property to applicable state and other agencies...."</p> <p>This Federal tag related to Complaint IN00157887.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure their abuse policy was implemented related to the reporting of an unusual occurrence within the facility. This deficient practice affected 1 of 3 residents reviewed for abuse. (Resident F)</p>	F000226	<p><b>F226</b> It is the practice of this facility to ensure the implementation of policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Corrective Action: Facility will follow Policy and Procedure related to</p>	11/28/2014

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	<p>her suspension even though she had reported the incident to RN #3.</p> <p>On 10/30/14 at 11:40 P.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated the allegation was not reported. The Director of Nurses further indicated it (allegation) did not occur and was viewed to be another incident of false allegations made against LPN #6 by CNA #1.</p> <p>On 10/30/14 at 2:15 P.M., the Director of Nurses provided an investigation that was dated 8/24/14. Review of the investigation, at that time indicated the following, "... the security cameras show that no incident occurred as CNA #1 says it did...The male resident was pulling himself along the railing and stopped momentarily in front of the female resident doorway. No female resident was visible in the doorway, and the male resident reached out to push himself off the door frame, and then continued to pull himself along the railing down the hall. The c.n.a.[CNA #1] was still in the dining room approx. same time the male resident stopped momentarily at the door, and then came down the hall &amp; spoke to another c.n.a. in the hall and turned around and walked away. The other c.n.a. continued to walk down the hall. Neither c.n.a. spoke to the male or female</p>			
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	<p>resident in question...."</p> <p>On 10/30/14 at 2:30 P.M., a current policy, provided by the Director of Nurses and titled, "...Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property....Revised April 2013...." was reviewed. The policy indicated the following:"...Reporting...2. Report the incident immediately to the Administrator and DON/designee, who will immediately report any allegations of mistreatment, neglect, abuse, including injuries of unknown source, and misappropriation of resident property to applicable state and other agencies...."</p> <p>This Federal tag relates to Complaint IN00157887.</p> <p>3.1-28(a)</p>				