STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155103		02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRONWOOD HEALTH AND REHABILITATION CENTER	1950 RIDGEDALE RD SOUTH BEND, IN 46614

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F 000 Bldg. 00	This visit was for an Recertification and State Licensure Survey. This visit resulted in an Extended Survey - Immediate Jeopardy. Survey dates: February 16, 17, 18, 19, 20, 21 and 22, 2015 Extended Survey dates: February 23 and 24, 2015 Facility number: 000042 Provider number: 155103 AIM number: 100291540 Survey Team: Pamela Williams, RN TC Sharon Ewing, RN (February 17, 18, 19, 20, 21, 22, 23, 24) Julie Baumgartner, RN (February 16, 17, 18, 19, 20, 22, 23, 24) Census bed type: SNF/NF:99 Total: 99 Census payor type: Medicare: 9 Medicaid: 75 Private: 6 Other: 9 Total: 99	F 000	Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the Provider of the truth or facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/ or exiecuted solely because it is required by the provisions of Federal and State Law. Ironwood Health and Rehabilitation Center desires that this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective March 25, 2015	

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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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on March 3, 2015, by Brenda Meredith RN.			
F 155 SS=K Bldg. 00	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on interview and record review, the facility failed to have a system in place to determine code status and failed to perform Cardiopulmonary Resuscitation on a resident who was a full code. (Resident #33) The facility also failed to ensure advanced directive/code	F 155	**We respectfully request informal dispute resolution (IDR) and a face-to face review of this deficiency.** Ironwood disagrees with F155 because it had a system in place for determining code status and Ironwood followed the advance directives of Resident #33 and	03/25/2015

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	status was clearly documented for 4 of 23 residents reviewed of the total census of 99 residents. (Residents #73, #146, #77, #9) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 11-20-14, when staff failed to ensure the code status of a resident was correctly documented and to perform Cardiopulmonary Resuscitation. The Administrator and the Director of Nurses were notified of the Immediate Jeopardy on 2-20-15 at 2:43 P.M. The Immediate Jeopardy was removed on 2-21-15, but noncompliance remained at the lower level scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: On 2-19-15 at 3:58 P.M., the clinical record for Resident #33 was reviewed. Resident #33 was admitted on 11-7-14 with diagnoses included, but not limited to, "...acute urinary tract infection, acute kidney injury, acute osteomylitis, alcohol abuse, chronic obstructive pulmonary disease, chronic wound of extremity and respiratory acidosis...." A facility form titled, "Admission		her court appointed guardian, both of whom did not want resuscitation or life sustaining measures provided. Please see attached IDR letter and documentation. **F155** It is the practice of the facility to provide services relation to code status. **Corrective Action:** Resident #33 no longer resides in the facility. 100% review of current residents to ensure appropriate physician orders and code status is present in each medical record completed on 2/20/15 by DON/UM/SSD. Re-education of 100% licensed nursing staff and Social Services in regards to code status policy with the expectation that the admitting license nurse verifies all code status components at the time of admission or with any change in code status, and with no staff working without education and was initiated on 2/20/15 at 430pm. Education provided by ETD/designee. **How Others Identified:** All new admissions, readmissions, significant changes, and updated resident/family/guardian decisions on code status will be reviewed by the Director of Nursing/designee to validate code status and ensure required components ie: physician order, code status form, state form and guardianship forms are completed and on the medical record daily until such time the QA committee recommends a	

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	Acceptance Information," inquiry date 10/22/14, indicated, "... Name: [resident name]... Diagnosis: Osteomylitis, Peripheral Vascular Disease...Contact Person: [Resident's sister]...Inquiry Date: October 22,2014....Clinical Status/Needs: Guardian...." A form titled, "[Name of local hospital] Patient Transfer Nurse Assessment-Extended Care," dated 11-7-14, indicated, "...Nurse Discharge Summary/Current Problem: S.O. [significant other] obtained guardianship today-pt.[patient] deemed incompetent...." A form titled, "[Name of local hospital] PHYSICIAN SUMMARY & TRANSFER ORDERS TO ECF [extended care facility]," dated 10-24-14 and 11-7-14, indicated, "...CODE STATUS: Yes Code... Physician Signature [physician's signature]...." A facility form titled, "ADVANCED DIRECTIVES POLICY AND RECORD," indicated, "...GUARDIANSHIP... Guardian of Person/Medical Decision Name of Guardian: [name of guardian]...DOCUMENTS RECEIVED...Date 11-7-2014...Initials [initials of facility staff]...."		decrease in oversight of the system but the minimum review decrease by QA will not exceed below the RAI/Regulatory requirements. **Preventative Measures:** Re-education of 100% licensed nursing staff and Social Services in regards to code status policy with the expectation that the admitting license nurse verifies all code status components at the time of admission or with any change in code status. **Monitoring:** DON/designee will conduct daily audit of 100% new or readmits in addition to random 10% on the in house charts to ensure components are in the medical records. In addition a minimum of 5 staff members across all shifts will be interviewed to ensure they can verbalize appropriate steps to determine code status and when to initiate a code. Results will be provided to the Administrator for presentation to the QA committee for further review and recommendations. **System Changes:** Completed by March 25, 2015	

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	A facility form titled, "Social Services Admission/Discharge Evaluation-Long Stay," dated 11-10-14, indicated under the Advanced Care Planning the "Resident is own person." A document titled, "ORDER APPOINTING TEMPORARY GUARDIAN FOR INCAPACITATED PERSON," dated 11-7-14, indicated the Court appointed a Temporary Guardian for Resident #33. A facility form titled, "PHYSICIAN'S MEDICATION ORDERS," dated 11-2014, indicated "...ADMISSION DATE:11/7/14...ADVANCED DIRECTIVES...CODE STATUS: Full Code...." A facility form titled, "(CPR) CARDIOPULMONARY RESUSCITATION CONSENT," indicated, "NO RESUSCITATION (No Cardiopulmonary Resuscitation or External Defibrillation)." The a signature was on the form and appeared to be the resident's signature. This form was not dated. There was no guardian signature or witness signature on the form. A nurses note, dated 11-11-14 at 3:10 P.M., indicated resident had experienced			

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	a seizure at 2:10 P.M. "POA [name of guardian] called and notified of all the above...." A nurses note, dated 11-12-14 at 10:00 A.M., indicated resident had been transported to (name of local hospital) for a blood transfusion. "POA [name of guardian] also called and informed of resident blood transfusion to be done at [name of local hospital]...." A nurses note, dated 11-19-14 at 3:30 A.M., indicated "has had no seizure activity noted this shift...." A nurses note, dated 11-20-14 at 12:30 A.M., indicated "Gave Norco PRN [as needed] for L [left] leg pain CNA [certified nurses assistant] got her some ice for her soda, she was pleasant et [and] talking [and] smiling. Took her updraft [breathing treatment] without problems et [and] Biox was 95% with O2 [oxygen] @ [at] 3L/nc [3 liters per nasal canula]...." A nurses note, dated 11-20-14 at 1:30 A.M., indicated "Res. [resident] resting peacefully with eyes closed @ this time. O2 [oxygen] in place...." A nurses note, dated 11-20-14 at 2 A.M., indicated "Incontinent of sm. [small] amt [amount] urine, changed [sic] et [and]			

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	voices no complaints. O2 [oxygen] in place et has had no seizure activity noted...." A nurses note, dated 11-20-14 at 3:00 A.M., indicated "Looked in on res. as was passing room, O2 in place et resting peacefully...." A nurses note, dated 11-20-14 at 5:00 A.M., indicated "Was preparing to take updraft to res.[resident] room. CNA [certified nurses assistant] requests to please come check on her. Found her cool to touch with no B/P [blood pressure] or Pulse...." A nurses note, dated 11-20-14 at 5:15 A.M., indicated "Left msg. [message] for her sister [name of sister] to please call facility, called POA [name of guardian] et notified him. States he will try to find a ride up here before calling funeral home...." A nurses note, dated 11-20-14 at 5:30 A.M., indicated "Obtained order from [name of physician] to release res body to funeral home of family choice. Left msg. for DON [Director of Nurses]...." On 2-19-15 at 5:22 P.M., an interview was conducted with the Social Worker. The Social Worker indicated the nursing			

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	department was responsible for the code status care plan. The Social Worker further indicated, "... I guess we [social services] don't do code status care plans. Nursing has the resident sign the CPR form, it should be done within 24 hours of admission...." On 2-19-15 at 5:26 P.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated, "... the nursing department does not do Advance Directive careplans...if a resident is admitted without guardian paperwork and the resident is alert and oriented the facility has the resident sign the paperwork...the nurse would look at the chart Advanced Directives to determine if a resident is full code or no code...I would look at the CPR consent, but it should have a date...the nurse should have obtained an order from the doctor that matched the CPR consent form that was signed. If the husband/boyfriend wanted her [Resident #33] to be a DNR [do not resuscitate] it would be his decision if she is deemed incompetent...." The current facility policy entitled, "Cardiopulmonary Resuscitation [CPR] -Basic Life Support [BLS]," dated April 2000, received from the Director of Nurses on 2/19/15 at 5:30 P.M.,			

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	indicated, "...Unless a decision not to initiate CPR has previously been made by the resident and State guidelines are in place, CPR will be initiated on any resident that experiences a witnessed or a unwitnessed cardiopulmonary arrest while in the center...." On 2-20-15 at 12:20 P.M., an interview was conducted with the Administrator and the Director of Nurses. The Director of Nurses indicated that, "...When a resident comes into the facility the nursing department is responsible to get the CPR form signed by the resident if they are alert and oriented. The code status is then placed on the POS [Physician Order Sheet]...if a resident changes their mind about their code status or a guardian comes up, the guardian needs to sign it [CPR consent form]...." When asked about Resident #33 and guardianship the Director of Nurses indicated she did not recall a guardian but she did recall that she was in the facility about 3 weeks and something about a boyfriend coming up. When discussing a system of monitoring code status of resident's, the Director of Nurses indicated that when a resident comes into the facility, the IDT (Interdisciplinary Team) a chart was taken to IDT for 3 days and reviewed. She indicated there was a check off list for medical records			

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	and a check off for nursing. IDT reviewed all new orders or changes in condition. Code status is talked about during care plan meetings. If the resident had a guardian, the admissions person would tell you. Sometimes the paperwork goes through the business office and it doesn't get communicated.... "On this one, admitting orders said full code, CPR consent said No Code, I would say it [signing of CPR consent form] was done upon admission. The nurse should have put a date on it. The nurse should have initiated CPR [cardiopulmonary resuscitation]...." A interdisciplinary team note for Resident #33, dated 11-11-14, indicated "... IDT met day 1 for admission to this facility on 11-7-14. Medication and treatment orders reviewed. Follow up appointments arrange with transportation and lab orders reviewed...." A interdisciplinary team note for Resident #33, dated 11-12-14, indicated "...IDT met day 2 of admission & new orders for lab due to seizure activity & sent to ER [Emergency Room] if resident develops Temp > [greater than] 101 or continues to have seizure...." A interdisciplinary team note for Resident #33, dated 11-13-14, indicated			

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	"...IDT met day 3 of admission & order to receive 2 units of PRBC [packed red blood cells] due to critical hemoglobin 7.2...." There was no documentation related to Advanced Directives/Code Status on the IDT notes. 2. On 2-20-15 at 9:52 A.M., record review for Resident #73 was conducted. No CPR Consent form was present on chart. Physicians orders, dated and signed 2-4-15 and 1-9-15, indicated that a code status was not established. 3. On 2-20-15 at 10:00 A.M., record review for Resident # 146 was conducted. A "Letter of Guardianship," dated 12-17-13, was included in the record. A "CPR Consent" form indicated, "No Resuscitation." The document was undated and unsigned by the Resident's Authorized Representative. 4. On 2-20-2015 at 11:00 A.M., record review for Resident #77 was conducted. The CPR Consent form indicated, "Resuscitation" dated 8-1-14. The " Physician orders, dated and signed 2-4-2015, indicated, "DNR." 5. On 2-20-15 at 11:05 A.M., record review for Resident #9 was conducted.			

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	No CPR consent form was found on chart. The Physicians orders, dated and signed 2-6-15, indicated that a code status was not established. On 2-23-15 at 11:12 A.M., LPN #2 indicated, "... they [facility staff] look for the CPR form first, but it isn't always there, sometimes the family does not come in and sign it so we would look for a physician order...." On 2/19/15 at 5:42 P.M., the Director of Nursing provided the procedure titled "Cardiopulmonary Resuscitation (CPR) - Basic Life Support (BLS)," and indicated the procedure was the one currently being used by the facility. The procedure indicated, "Unless a decision not to initiate CPR has previously been made by the resident and State guidelines are in place, CPR will initiated on any resident that experiences a witnessed or unwitnessed cardiopulmonary arrest while in the center." The Immediate Jeopardy that began on 11-20-14 was removed on 2-23-15, with an effective date of 2-21-15, when through record reviews and interviews, staff had completed education regarding the facility policy and procedure related to CPR. The facility had also reviewed all records to ensure advanced			

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	directives/code status was correct for each resident. Even though the facility's corrective action removed the Immediate Jeopardy the facility remained out of compliance at a reduced scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not an Immediate Jeopardy because of on-going monitoring to ensure the staff were knowledgeable and the resident's advanced directive/code status was documented correctly. 3.1-f(5)			
F 157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).			

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	The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, record review and interview, the facility failed to notify a resident's physician of a blood sugar that was outside of the blood sugar monitoring parameters for 1 of 5 residents who met the criteria for unnecessary medications (Resident #153); and, to notify the residents physician of a significant weight loss for 1 of 3 records reviewed for weight loss. (Resident #9) Findings include: 1. The clinical record for Resident #153 was reviewed on 2-19-15 at 9:58 A.M. Resident # 153 was admitted, on 1-31-15, with diagnoses including, but not limited to, diabetes mellitus type 2. A physicians order related to sliding scale insulin, without an order notation date but discontinued on 2-14-15, indicated	F 157	**F 157** It is the practice of this facility that the resident, resident's physician and resident's family or legal representative will be informed when there is a change of condition requiring a physician intervention related to blood sugar that was outside of the blood sugar parameters and significant weight loss. **Corrective Action:** Resident #153 no longer resides in the facility. Res #9 chart has been reviewed, physician notified and POC is reflective of current status. Physician has been notified of those residents who have had a recent significant weight loss. Nurses and nurse mangers will be re-educated on physician notification and then documentation of this notification. This notification will be placed in the medical record on the SBAR or nursing notes, and 24 hour report. **How Others Identified**: Residents will have the above process completed with each significant	03/25/2015

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 02/24/2015
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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	the following, Novolog (a medication used to lower blood sugar) Sub q (subcutaneous) sliding scale ac (before meals) and hs (bedtime): 150-200 give 2 units; 201-250 give 4 units; 251-300 give 6 units; 301-350 give 8 units; 351-400 give 10 units; > (greater than) 400 call MD (Medical Doctor). Review of Resident #153's capillary blood glucose monitoring tool and nurses notes indicated a lack of physician notification for the following blood sugar levels: 2/13/15 at 8:00 P.M., blood glucose documented 483. Physician notification was not documented in the clinical record. During an interview, between 12:00 P.M. and 1:00 P.M., LPN #27 indicated "... I did call the doctor regarding the increased blood sugar I gave 10 units of insulin and called but I was here working over and trying to go home and LPN #28 was beside me when I called so I asked her to chart the call and note the orders. I did not chart because LPN #26 said she would chart it...." On 2-19-15 at 3:30 P.M., a current policy, provided by the Director of Nurses and titled " Notification of change" was reviewed. The policy		weight loss and any blood sugar that is outside of the blood sugar parameters. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. **Preventative Measures:** The DON and/or designee will obtain weights as needed and pull reports to validate weekly and monthly weights. The UM and/ or designee will notify physician of any significant weight loss and document this notification. Nurses will notify physician of any blood sugar that is outside of the blood sugar monitoring parameters and document this notification. **Monitoring:** DON will monitor weights weekly and monthly. UM and/or designee will monitor diabetic logs and physician notification 5x/week x2weeks, 3x week x 4 weeks, weekly x 4 weeks, monthly thereafter. 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. **Systems Changes:** Competed by March 25,2015	

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	indicated, "... Notification of Resident Change in Condition...Procedure...1. Notify the Physician and family or legal representative at the earliest possible time, during waking hours, if there is a non-critical change in condition (unless requested to do otherwise)...." 2. The clinical record for Resident #9 was reviewed on 2/20/15 at 11:05 A.M. The diagnoses included, but not were not limited to, "... hypertension nos [nonspecific], urinary retention, muscle weakness, convulsions, brain injury, cholangiocarcinoma..." The Nutrition Progress Note, dated 8/26/14, indicated "CBW [current body weight] [8/25] 219.8# sig [significant] wt [weight] loss -11.2% x [times] 6 mth [month] noted...." The Nutrition Progress Note, dated 9/17/14, indicated "Per Sept [September] [9/16] 206.2# resident with -5.23% x 1, -11.12% x 6 mth...." The Nutrition Progress Note, dated 10/20/14, indicated "Per Oct [October] [10/6] 202.8# resident with sig wt variance -9.62% x 3 mth, -18.22% x 6 mth...." The Nutrition Progress Note, dated 12/15/14, indicated " Per [12/11] 195.2#			

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	sig wt variance -8.69% x 1 mth, -8.01% x 3 mth...." The Nutrition Progress Note, dated 1/6/15, indicated "CBW [current body weight] 187#. Sig wt variance -7.7% x 3 mth , -16.6% x 6 mth...." The Nutrition Progress Note, dated 2/3/15, indicated "Per Feb [February] wt [2/2] 188# resident with sig wt [symbol for loss] -12.06% x 3, -13.6% x 6 mth...." The progress notes, dated 10/2/14 to 2/22/15, and the IDT (Intra Disciplinary Team) notes, dated 8/25/14 to 2/20/15, indicated there was no documentation that the physician was notified of Resident #9's weight loss. During an interview on 2/19/15 at 4:00 P.M., the Registered Dietician indicated "... once a weight loss is identified with a resident ... nurses notify physician, I don't...." During an interview on 2/24/15 at 3:20 P.M., the DON (Director of Nursing) indicated "... if weight loss is identified myself or the unit managers notify the physician... a SBAR [Situation Background Assessment Request] Communication form would be filled out			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	for a significant change in condition such as weight loss... physicians should be notified of a resident with weigh loss...." On 2/24/15 at 3:00 P.M., the current Procedure, "Notification of Resident Change in Condition and Nutritional Status," was received on 2/24/15 at 2:28 P.M. from the Administrator. The procedure indicated "... clinicians will immediately inform the ... resident's physician...when there is a significant change on the resident's condition... 10. Reported weight loss/ gain of 5% to the Physician... and obtain order as appropriate...." 3.1-5(a)(2) 3.1-5 (a)(3)			
F 282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to follow the plan of care for physician notification of a resident with a blood sugar that was outside of the blood sugar monitoring parameters for 1 of 5 residents who met the criteria for unnecessary medications. (Resident #153) The facility also failed	F 282	**F282** It is the practice of the facility that services are provided in accordance with each resident's written plan of care. **Corrective Action:** Resident #153 no longer resides in the facility. Resident #136 chart has been reviewed and POC is reflective of current status. Nurses and Nurse managers will be re-educated on	03/25/2015

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	to ensure physicians orders were followed for nutritional supplements for 1 of 1 residents. (Resident #136) Findings include: 1. The clinical record for Resident #153 was reviewed on 2-19-15 at 9:58 A.M. Resident # 153 was admitted, on 1-31-15, with diagnoses including, but not limited to, diabetes mellitus type 2. A physicians order related to sliding scale insulin, without an order notation date but discontinued on 2-14-15, indicated the following, Novolog (a medication used to lower blood sugar) Sub q (subcutaneous) sliding scale ac (before meals) and hs (bedtime): 150-200 give 2 units; 201-250 give 4 units; 251-300 give 6 units; 301-350 give 8 units; 351-400 give 10 units; > (greater than) 400 call MD (Medical Doctor). A care plan, initiated 2-2-15 and revised 2-17-15, indicated, "...Diabetes Plan of Care...Assessment...Potential for Alteration/Alteration in Blood Glucose Levels related to Insulin dependant diabetes...Interventions...Follow up with physician as needed...." Review of Resident #153's capillary blood glucose monitoring tool and nurses		following physician orders and physician notification. This notification will be placed on the SBAR or nursing notes, 24 hour report and dietary communication form when needed. Dietary meal tickets were reviewed to reflect residents current POC. **How Others Identified:** Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. **Preventative Measures:** Nurses will notify physician of any blood sugar that is outside of the blood sugar monitoring parameters and document this notification in the medical record. All new orders, including dietary orders are reviewed daily in triage with dietary manager/ designee present. **Monitoring:** UM and/or designee will monitor diabetic logs and physician notification 5xweek x2weeks, 3x week x 4 weeks, weekly x 4 weeks, monthly thereafter. Dietary manager/designee will monitor meal tickets and trays for ordered supplement, 10% 5 days a week x 2 weeks, then 5% 5 days a week x 2 weeks then all new orders thereafter. 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	

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	notes indicated a lack of physician notification for the following blood sugar levels: 2/13/15 at 8:00 P.M., blood glucose documented 483. Physician notification was not documented in the clinical record. During an interview, between 12:00 P.M. and 1:00 P.M., LPN #27 indicated "... I did call the doctor regarding the increased blood sugar I gave 10 units of insulin and called but I was here working over and trying to go home and LPN #28 was beside me when I called so I asked her to chart the call and note the orders. I did not chart because LPN #28 said she would chart it...." On 2-19-15 at 3:30 P.M., a current policy, provided by the Director of Nurses and titled "Notification of change" was reviewed. The policy indicated, "... Notification of Resident Change in Condition...Procedure...1. Notify the Physician and family or legal representative at the earliest possible time, during waking hours, if there is a non-critical change in condition (unless requested to do otherwise)...." 2. On 2/19/15 at 10:06 A.M., the clinical record for Resident #136 was reviewed. The diagnoses included, but were not limited to, "...Dementia, urinary		identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. **System Changes:** Completed by March 25, 2015	

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	155103		02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRONWOOD HEALTH AND REHABILITATION CENTER	1950 RIDGEDALE RD SOUTH BEND, IN 46614

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	incontinence, diabetes type 2 with episodes of hypoglycemia...." The physician orders, dated 1/7/15, indicated "Magic Cup with meals, Med Pass 2.0 TID [three times daily] 30 cc Health shakes TID b/w [between] meals...." On 2/19/15 At 12:10 P.M., an observation of Resident #136's lunch indicate she had a puree meat, vegetable and was drinking a health shake. No magic cup was observed on the table. During an interview on 2/19/15 at 12:54 P.M., LPN #10 indicated " ...resident should have magic cup with meals...." 3.1-35 (g)(2)			
F 312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to provide showers and oral care for 1 of 35 residents. (Resident #9) Finding includes:	F 312	**F312** It is the practice of the facility to ensure that residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	03/25/2015

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	On 2-17-2015 at 9:43 A.M., an interview with Resident #9 was conducted. Resident #9 indicated, "...I normally get a bed bath on Monday and Friday, I used to get one on Mondays, Wednesdays and Fridays...not sure why I don't anymore...I would take a shower everyday if I could...yesterday was a shower day, she [CNA-Certified Nursing Assistant] came in and said she would be back to give me one, she never came back...so I have to wait until Friday [to have a shower] because they don't have time...." Resident #9 indicated, "... I can brush my own teeth if they bring me what I need...I haven't had my teeth brushed since last Thursday...I would like to brush my teeth 3 times a day...." Resident #9's teeth were observed to have a build up of a white substance between each tooth and along the gum line. Resident #9 indicated, "...I ask for my toothbrush but they forget...." On 2-20-2015 at 11:05 A.M., the clinical record for Resident #9 was reviewed. The diagnoses included, but were not limited to, "...hypertension, urinary retention, muscle weakness, convulsions, brain injury, cholangiocarcinoma...." The MDS (Minimum Data Set) assessment indicated Resident #9's BIMS (Brief Interview for Mental Status) as 15/15, cognitively intact.		**Corrective Action:** Resident #9 has been re-interviewed for preferences and care plans to ensure reflective of current status. Resident bath type detail to be reviewed 5x/week during morning meetings by DON/or designee and UM. Nursing staff has been re-educated on providing ADL care and documentation. **How Others Identified:** Residents residing in the facility will be reviewed for ADL care and bath type and will be addressed by following policy and procedure and re-educated and/ or disciplinary action of employees will be addressed by following policy. **Preventive Measures:** Nursing staff has been re-educated on providing ADL care and documentation per policy. **Monitoring:** The UM and/or designee will review bath detail reports 5x/week for any refusal of showers. 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. **Systems Changes:** Completed by March 25,2015	

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	On 2-20-2015 at 12:25 P.M., a review of the shower sheet for Resident #9, dated 2-16-2015, indicated "Refused not feeling well." The progress notes, dated 2-16-2015, did not document the shower refusal or that Resident #9 did not feel well that day. On 2-23-2015 at 3:25 P.M., the 400 Hall Unit Manager indicated, "...I expect once per shift and prn [as needed] for oral care to be done by the CNA's for each resident...showers need to be given on their shower day and if the resident refuses, the CNA needs to tell the nurse in charge of that resident so she can confirm it [the refusal]...then the nurse should make note of the refusal in the progress notes...." On 2-23-2015 at 3:49 P.M., CNA #24 indicated, "...I have worked this hall since starting here last May...I take care of him [Resident #9] almost every time...he [Resident #9] can brush his teeth but we usually help him...I have never helped him brush his teeth...we should do oral care when we are getting them ready for bed...." On 2-23-2015 at 5:06 P.M., the DON (Director of Nursing) indicated that oral			

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	care should be done upon rising and before bed and if a resident refuses a shower, the nurse should be made aware and confirm the refusal. On 2-24-2015 at 2:28 P.M., an interview with the Administrator, indicated that there is no policy related to showers or oral care but they are part of the orientation process for the CNA's. 3.1-38(a)(3)(A) 3.1-38(a)(3)(C)			
F 325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to prevent weight loss for 1 of 3 sampled residents who met the criteria for weight loss. (Resident #136)	F 325	**F325** It is the practice of this facility to maintain nutritional status. **Corrective Action:** Resident #136 chart has been reviewed and POC is reflective of current status. Residents with significant weight	03/25/2015

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	Finding includes: On 2/19/15 at 10:06 A.M., the clinical record for Resident #136 was reviewed. The diagnoses included, but were not limited to, "...Dementia, urinary incontinence, diabetes type 2 with episodes of hypoglycemia...." Resident #136's MDS (Minimum Data Set) assessment, dated 1/14/15, indicated a BIMS (Brief Interview for Mental Status) "... of 3 out of a possible 15, indicating severe cognitive impairment...." The physicians order dated 1/7/15 with indicated " Magic Cup with meals, Med Pass 2.0 TID [three times daily] 30 cc Health shakes TID b/w [between] meals...." The Nutrition Risk Data Collection and Assessment, dated 1/12/15, indicated "...Functional Problem/ Feeding Ability: Supervision/ set up... Cognitive/ Behavior/ Communication: A/Ox1 [alert and oriented to person]... Goals, Strategies, Interventions: Tolerate diet, Maintain weight...." The Nutrition Risk Data Collection and Assessment Summary, dated 11/4/14,		loss have been reviewed by dietary and nursing for any needs. Dietary and nursing will provide interventions and make recommendations as needed. **How Others Identified:** Residents will have the above process completed with significant weight loss. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. **Preventative Measures:** The DON and/or designee will obtain weights as needed and pull reports to validate weekly and monthly weights. Re-educate nursing staff on following policy regarding physician orders. Any identified concerns will be addressed in triage and or/ daily clinical review. **Monitoring:** The DON and Dietician and/or designee will meet weekly and monthly to review significant weight changes. Dietician /or designee and DON/designee will review residents with significant weight change for needed interventions and make recommendations as needed. 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	

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	indicated "... RD [Registered Dietician] ...Resident moved to Dementia unit... Avg [average] po [oral] 67%. Recommend health shake at HS [bedtime]...." The Nutrition Risk Data Collection and Assessment Summary, dated 12/9/14, indicated "...RD note: Per Dec [December] wt [12/8 136# sig [significant] wt [symbol loss] -5.5% x 1 month... Reinitiate health shakes at @ [at] HS. Nutrition goal remain the same...." The Nutrition Risk Data Collection and Assessment Summary, dated 1/6/14, indicated "...per January wt [1/5] 130.63 resident with sig wt variance -12.17 % x 3 mth... Avg po 31% not sufficient to meet needs. Recommend HS [Health shake] @ HS. Not ordered..." The Nutrition Risk Data Collection and Assessment Summary, dated 1/12/15, "... Avg po 39% CBW [current body weight] (1/12) 125.8# sig wt loss 7.5% x1 mth -15.4 % x 3 mth...." The Nutrition Risk Data Collection and Assessment Summary, dated 2/5/15, "... Per Feb [February] wt (2/3) 126 # sig wt change -12.5 % x 3 months, stable x 1 month...."		to the administrator for review and presented to QA to determine further educational needs. **Systems Changes:** Competed by March 25,2015	

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IRONWOOD HEALTH AND REHABILITATION CENTER	1950 RIDGEDALE RD SOUTH BEND, IN 46614

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	On 2/19/15, between 12:10 P.M. and 12:54 P.M., the following interviews and observations were conducted during Resident #136's lunch meal: *At 12:10 P.M., an observation of Resident #136's lunch indicate she had a puree meat, vegetable and was drinking a health shake. No magic cup was observed on the table. *At 12:14 P.M., CNA #25 was observed reminding Resident #136 to drink her shake. *At 12:15 P.M., CNA #25 indicated "[Resident #136] is drinking health shakes...she has had two so far...." *At 12:20 P.M., CNA #25 was observed reminding Resident #136 to drink her shake. *At 12:25 P.M., CNA #25 was observed reminding Resident #136 to eat. *At 12:30 P.M., CNA #25 was observed reminding Resident #136 to drink her drink. *At 12:35 P.M., an observation of Resident #136's lunch ticket indicated that no magic cup was ordered. *At 12:40 P.M., CNA # 25 indicated "... if resident had a health shake or a magic cup ordered it would be on lunch ticket ...." *At 12:45 P.M., CNA #25 Indicated to LPN #10 "... [resident name] drank 480 cc [cubic centimeters]... but ate			

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 02/24/2015

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	nothing...." *At 12:50 P.M., Resident #136 lunch was removed from in front of her. At no time throughout the lunch meal was resident observed to be assisted to eat her meal. *At 12:54 P.M., LPN #10 indicated " ...Resident #136 should have magic cup with meals...." During an interview on 2/19/15 at 4:00 P.M., the Registered Dietician indicated "... the residents meal ticket would indicate if the resident was to receive a supplement like house shake or magic cup...she does not make the decision that a resident should be fed or moved to the assisted table." During an interview on 2/19/15 at 4:43 P.M.,., the DON (Director of Nursing) indicated "... she is notified by CNA's, nurses, or unit manager if a resident has declined... yes [Resident #136] has had a recent decline...." During an interview on 2/20/15 at 9:27 A.M., LPN #10 indicated "...we let dietary know the resident needs to be moved to the feeder table... the dietary manager makes the decision to move the resident to the feeder table...." During an interview on 2/20/15 at 11:00 A.M., CNA # 11 indicated "... if a			

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	resident didn't consistently eat we would move them to the assisted table... we make that decision to move them to the other table...." During an interview on 2/21/15 at 12:05 P.M., the Dietary Manager indicated "...it is not my decision to advance resident from cueing assistance to being fed...." During and interview on 2/24/15 at 9:17 A.M., the DON (Director of Nursing) indicated "...if a resident is not feeing themselves you assist them...you pick up the utensils and feed them... not forcing them of course...." On 2/24/15 at 2:28 P.M., review of the procedure titled " Weight monitoring" provided by the Administrator indicated" ...6... Encourage residents to consume all foods... during meals...." The policy did not indicate if a resident should be fed. 3.1-46(a)(1) 3.1-46(a)(2)			
F 334 SS=D Bldg. 00	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives			

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	155103		02/24/2015

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	education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education			

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	regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Based on record review and interview, the facility failed to ensure a resident who requested an influenza vaccination received one in a timely manner. This deficient practice affected 1 of 5 residents who were reviewed for influenza immunization. (Resident #51) Finding includes: The clinical record for Resident # 53 was reviewed on 2-24-15 at 11:40 A.M. Resident #53 was admitted to the facility, on 10-27-14, with diagnoses, including but not limited to, dementia, chronic obstructive pulmonary disease and shortness of breath related to anxiety/chronic obstructive pulmonary disease. A physicians order, dated 1-8-15,	F 334	**F334** It is the practice of this facility to provide the annual influenza vaccine in a timely manner. **Corrective Action:** Resident #51 chart has been reviewed and has received the annual influenza vaccine. Resident charts will be audited to ensure the annual influenza vaccine has been given per the annual influenza consent. **Preventative Measures:** Nurses will be re-educated on the policy and procedure for offering and administering the influenza vaccine. **Monitoring:** UM and /or designee will monitor new residents charts for follow up with the above policy during Daily Clinical Review. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded	03/25/2015

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	indicated, "... May Receive Flu Vaccine...Please Send...." A facility form titled, "Immunization Record," dated 1-8-15, lacked documentation to indicate the influenza immunization had been given. During an interview on 2-24-15 at 11:54 A.M., Unit manager #3 indicated, "...I do not believe he received it [flu shot] when we originally gave them. I believe he was gone to the hospital. We give flu shots until flu season is over...." On 2-24-15 at 12:00 p.m., review of the current "Immunizations-Standing Orders" procedure, last revised November 2014, and received from the Director of Nurses indicated, "... Influenza Vaccine...b. Influenza vaccine will be administered during the optimal time for immunizations, which is usually October to November. However, the CDC [Centers for Disease Control] has now defined influenza season by whether or not influenza is circulating in the centers geographic area...." 3.1-13(a)		to the administrator for review and presented to QA to determine further educational needs. **System Changes:** Completed by March 25,2015	
F 371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY			

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	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to store and serve food under sanitary conditions in regards to proper use of hairnets, insufficient handwashing, food service and a clogged floor drain. This had the potential to effect 97 of 99 resident receiving meals from 1 of 1 kitchen. Findings include: On 2-16-2015 at 10:25 A.M., an initial kitchen tour was conducted. Employee #7 was sitting in the dry storage without a hairnet or other hair covering on his head. The NSM (Nutritional Services Manager) indicated, "...he [Employee #7] knows he should have a hairnet on...." The dry storage area had approximately 40 cans of soup, vegetables and fruit that were not marked with a received date. The NSM indicated, "...the cans were to be marked with a date as to when they were received and stocked onto the storage cart and Employee #7 usually does the stocking...." Employee #7 indicated, "...she has told me 3 times and I just started doing it with the new stock...." An	F 371	**F371** It is the practice of this facility to prepare and serve in sanitary conditions in regards to hand-washing and to store, prepare, distribute and serve food under sanitary conditions. **Corrective Action:** Staff have been re-educated on the appropriate hand-washing technique. Food is being monitored to assure it is distributed and served under sanitary conditions per facility policy in regards to dating cans at time of delivery, proper use of hairnets, hand washing procedure, direct food service to residents in dining rooms. Floor drain corrected on 3/10/2015. Tile work was completed on 3/17/2015. The door has been cleaned and repaired on 3/17/2015. The dietary dry storage floor was cleaned on 2/16/2015. **How Others Identified:** Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. For all residents of the facility, food is being distributed and served under sanitary conditions per facility policy. Staff has been re-educated through in-services, regarding the wearing of hairnets,	03/25/2015

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	observation was made of a dried sticky substance on the floor in the dry storage unit. The NSM indicated, "...I am not sure what that is but it should be cleaned up...." On 2-16-2015 at 10:30 A.M., a drain in the floor of the kitchen, located to the left of the ice machine, was observed to have water covering it. The ice machine had a drain pipe that ran to the drain in the floor. The tiles surrounding the floor drain were broken and some of the grout was missing. An exterior door, located behind the ice machine and about 4 feet from the floor drain, was observed to have peeling paint and a black substance on the trim that surrounded the door, from the floor to approximately 12 inches up from the floor. The NSM indicated, "...the water stands there all the time...this is the only drain in the kitchen...they clean it out every 2 weeks but we always have water standing...it has a smell to it at times...they were supposed to fix it...I see the black stuff on the trim, it looks like it could be mold...." On 2-16-2015 from 11:40 A.M. to 11:54 A.M., an observation of lunch service in the locked dementia unit dining room was conducted. The following was observed:		hand washing, and the correct method to handle table ware while serving residents. **Preventive measures:** All Staff re-educate d on appropriate hand-washing techniques. Dietary staff has been re-educated on policy regarding hairnets and handling of tableware while serving residents. **Monitoring:** The UM, dietary manager, and /or designee will monitoring dining room for hand-washing techniques 5x weekx 2 weeks, 3x weekx 2 weeks , weekly for 4 weeks and then monthly for 3 months. Nutritional Service Manager/Designee will monitor the wearing of hairnets, correct method of handling table ware when serving residents daily times 2 weeks, then 3 times a week for 2 weeks, weekly for 1 month then monthly to assure proper procedures are being maintained. Nutritional Service Manager will monitor dating of cans at time of delivery for all deliveries for 1 month and spot check for compliance on a continuing basis. Maintenance will monitor the floor drain in the preventative maintenance program monthly. 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 on one re-education up to and including termination. Any identified trends will be forwarded to the	

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	At 11:48 A.M., CNA (Certified Nursing Assistant) #11 washed her hands for 12 seconds before serving a tray of food to a resident. CNA #11 served a cup of juice and a cup of fruit with the palm of her hand over the opening of the cup. At 11:50 A.M., LPN (Licensed Practical Nurse) #10 washed her hands for 5 seconds before serving a tray of food to a resident. LPN #10 served a cup of fruit with the palm of her hand over the opening of the cup. At 11:54 A.M., LPN #10 washed her hands for 3 seconds before serving a tray of food to a resident. On 2-16-2015 from 11:56 A.M. to 12:09 A.M., an observation of lunch service in the main dining room was conducted. The following was observed: At 11:58 A.M., the NSM washed her hands for 10 seconds before serving a tray of food to a resident. At 12:00 P.M., the CRC (Clinical Reimbursement Coordinator) served a cup of juice to a resident, picking the cup up by the rim. At 12:03 P.M., CNA #22 was observed serving a plate of food to a resident with		administrator for review and presented to QA to determine further educational needs. **Systems Changes:** Completed by March 25, 2015	

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	her thumb on the plate. At 12:07 P.M., CNA #13 was observed serving a plate of food to a resident with her thumb on the plate. On 2-16-2015 from 12:10 P.M. to 12:25 P.M., an observation of lunch service in the assisted dining room was conducted. The following was observed: At 12:11 P.M., CNA #12 washed her hands for 10 seconds before serving a tray of food to a resident. CNA #12 served a cup of fruit with the palm of her hand over the opening of the cup. At 12:13 P.M., CNA #13 washed her hands for 15 seconds before serving a tray of food to a resident. At 12:14 P.M., CNA #14 washed her hands for 15 seconds before serving a tray of food to a resident. At 12:15 P.M., LPN #15 washed her hands for 9 seconds before assisting a resident with his meal. At 12:18 P.M., LPN #16 washed her hands for 11 seconds before assisting a resident with her meal. On 2-23-2015 at 4:20 P.M., an interview			

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	155103		02/24/2015

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	with the ETD (Education and Training Director) was conducted. The ETD indicated, "...we encourage staff to wash hands for 20 seconds...." On 2-24-2015 at 2:28 P.M., the review of the policy, "Nutrition Services Practice Manual," revised April 2014, received from the Administrator as the current policy, indicated, "...Sanitation Procedures...Procedure...Personal Hygiene...1. Rub hands together vigorously for 20 seconds per food guidelines [or according to State regulations], generating friction on all surfaces of the hands and fingers...3. Wear a hair restraint at all times...." On 2-24-2015 at 3:43 P.M., the DON (Director of Nurses) indicated, "...the staff should wash their hands for 20 seconds before serving residents in the dining rooms...they should not touch the rim of the cups when serving the residents...." On 2-24-2015 at 3:53 P.M., the NSM indicted, "...hair nets are to be worn by anyone who is in the kitchen as soon as they enter the kitchen...there are hair nets by both the doors for staff to put on...." 3.1-21(i)(2)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRONWOOD HEALTH AND REHABILITATION CENTER	1950 RIDGEDALE RD SOUTH BEND, IN 46614

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F 431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure only authorized personnel had access to 1	F 431	**F431** It is the practice of the facility to ensure only authorized personnel have access to locked medication rooms. **Corrective Action:** All Nurses and	03/25/2015

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	155103		02/24/2015

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IRONWOOD HEALTH AND REHABILITATION CENTER	1950 RIDGEDALE RD SOUTH BEND, IN 46614

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	of 4 locked medication rooms. (100 Hall) Finding includes: On 2-20-15 at 10:25 A.M., an employee of (name of local laboratory company) was observed to be let into the the 100 hall medication room by LPN (Licensed Practical Nurse) #8. LPN # 8 left the employee in the medication room and then returned to the nurses station where she retrieved a chart and returned to the medication room. During an interview with LPN #8 conducted at that time indicated, "... He is from the lab at [name of company] they keep all their equipment and supplies back here he is just here for pick up...." On 2-20-15 at 10:28 A.M., an interview was conducted with the DON (Director of Nurses). The DON indicated, "The only person who is authorized to be in the medication room unsupervised is the nurse." On 2-20-15 at 11:30 A.M., review of the current policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles," effective date 12-1-07, received from the DON at this time, indicated, "... Procedure: 1. Facility should ensure that only authorized		Nurse managers will be re-educated on the policy of medication rooms. **How Others Identified:** Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. **Preventative Measures:** The lab equipment and supplies have been moved to another area that has been designated for just laboratory equipment. **Monitoring:** UM and or/ designee will observe for any unauthorized personnel entering medication rooms without proper supervision. 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. **System Change:** Completed by March 25,2015	

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	Facility staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law...." 3.1-25(m)			
F 441 SS=D Bldg. 00	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.			

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(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
	(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 observation, interview and record review, the facility failed to ensure a sanitary environment and to help prevent the development and transmission of disease and infection in relation to proper hand washing during medication administration. This had the potential to affect 3 of 3 residents observed for medication administration. (Resident #13, Resident #49, Resident #36) Finding includes: On 2/21/15 at 11:34 A.M., LPN # 18 was observed washing her hands for 8 seconds then was observed licking her finger, turning the pages in the MAR (Medication Administration Record). She then pushed Resident #13 into her room, put on gloves and checked the residents blood sugar. LPN #18 then washed hands	F 441	**F 441** It is the practice of this facility to establish and maintain a sanitary environment and to help prevent the development and transmission of disease and infection in relation to proper handwashing during medication administration. **Corrective Action:** All Nurses have been re-educated on proper handwashing technique. **How Others Identified:** Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. **Preventive Measures:** : All nurses re-educated on proper handwashing technique. **Monitoring:** UM and /or designee will monitor a medication pass for hand-washing techniques 5xweek x2 weeks, 3 x week x 2weeks, weekly for 4 weeks and then monthly for 3 months. Trends will be reviewed in	03/25/2015

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 02/24/2015

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	for 5 seconds. On 2/21/15 at 11:52 A.M., LPN #19 was observed washing her hands for 8 seconds, put on gloves and then checked Resident # 49's blood sugar. On 2/21/15 at 12:55 P.M., LPN #18 was observed washing her hands for 5 seconds then passed medications to Resident #36. On 2/24/15 at 2:28 P.M., the Administrator provided the the current procedure titled, "Hand Hygiene- Plain Soap and Water Handwash." The procedure indicated "...6. Rub hands together vigorously for 15-20 seconds generating friction on all surfaces if the hands and fingers...." During an interview on 2/24/15 at 3:20 P.M., the DON (Director of Nursing) indicated "...hands should be washed or alcohol based gel should be used in between each medication pass ...hands should be washed for 20 seconds... you should not lick fingers to turn pages in MAR...." 3.1-18(l)		QA monthly times 3 months and quarterly thereafter to determine further education and/ or further monitoring needs. Identified non-compliance will result in one on 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. **Systems Changes:** Completed by March 25,2015	