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 02/12/2014

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

(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
F000000	This visit was for an Investigation of Complaint #IN00144084. Complaint #IN00144084 - Substantiated. Federal/State deficiencies related to the allegations are cited at F456 and F465. Unrelated deficiency is cited. Survey dates: February 11, and 12, 2014. Facility number: 000042 Provider number: 155103 AIM number: 100291540 Survey team: Shelly Miller- Vice, RN Census bed type: SNF/ NF: 106 Census payor type: Medicare: 6 Medicaid: 85 Other: 15 Total: 106 Sample: 3 These deficiencies reflect state	F000000	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 this Statement of Deficiencies. The Plan of Correction is prepapred and/or execited 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 14, 2014.	

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.

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	findings cited in accordance with 410 IAC 16.2. Quality Review completed on February 18, 2014, by Brenda Meredith, R.N.			
F000170 SS=D	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. Based on record review, observation and interviews, the facility failed to assure Resident #D received unopened mail in a timely manner. This affected 1 of 106. Findings included: On 2/11/14 at 2:15 p.m., a tour was conducted of the Activities Closet on the 300 unit indicating a locked doorknob handle that did not secure the closet from being freely opened. Upon observation of the closet, it was noted to include a piece of unopened mail addressed to Resident #D. The envelope was address side down-ward and dust was littered on it.	F000170	F 170What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The unopened mail for resident D was given to the resident's guardian for review and the activities closet on the 300 unit is now properly fitted with a door handle that does secure the closet from being freely opened. The Activity Director will ensure that all resident mail will be delivered to residents/ responsible parties immediately after the delivery of mail to the facility. In the absence of the Activity Director, the Director of Social Services will retain the responsibility of ensuring that all resident mail is properly distributed after receipt by the facility. The activities closet has been cleaned and the	03/14/2014

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	On 2/11/14 at 2:16 p.m., an interview with the Activities Coordinator of the 200 unit indicated that Resident #D was a resident of the 200 unit. On 2/11/14 at 2:18 p.m., a record review was conducted of Resident D's clinical medical record indicating he was not cognitively intact to understand mail. Resident #D's diagnoses included, but not limited to, Vascular Dementia with behaviors, organic paranoid psychosis and diabetes type 2. The Brief Interview for Mental Status (BIMS) was unable to be evaluated due to, "Severe impairment." A guardian was identified for communication. On 2/11/14 at 2:20 p.m., record review was conducted with the interim Administrator indicating a Policy titled,"Mail- Resident Receiving and Sending....Procedure: 1. Designate a member of the Life Enrichment Department to pick up resident's mail daily when it is delivered by the postal service....3. Deliver the mail, unopened to the applicable resident's room.... Bills and/or legal mail of confused/ disoriented resident will be		housekeeping staff does monitor all facility closets to ensure that cleaning is completed on an on-going basis. The Housekeeping Director has developed an auditing tool that will allow for the maintenance of on-going compliance.The Administrator did in-service the Activity Director as to the importance of daily resident mail delivery and as to the proper protocol to follow when completing resident mail delivery logs. The Administrator did also in-service the Housekeeping Director as to the daily checking of resident living areas and facility closets to ensure that all needed cleaning concerns can be addressed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken?All residents have the potential to be affected by the alleged deficient practice. The Activity Director will interview all facility residents and/or resident responsible parties to ascertain whether other facility residents do have concerns with resident mail delivery services. The Activity Director will additionally retain responsibility for the daily logging of resident names that have not properly received delivery of personal mail. The log will indicate the reasons as to why the resident’s mail was not delivered. The Administrator will review the	

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	forwarded to the legal representative or family member." On 2/11/14 at 2:21 p.m., an interview was conducted with the interim Administrator indicating the Activities Director was responsible for delivering mail to the residents. On 2/11/14 at 2:30 p.m., an interview was conducted with the Activities director indicating,"...when the mail is delivered to the facility, it is placed into my personal staff mailbox. Then, I pick it up during my working hours and deliver it. If it is to a resident who is unable to understand, I forward to their family or representative... when I am not here, the 200 hall does get it or I will assign it to someone to deliver to the unit then the staff will take it from there... I have no idea how long that mail had been in the activities closet... yes, if it was being swept out routinely, it would have been found...." 3.1-3(s)(1)		log on a weekly basis to ensure that residents are receiving proper delivery of personal mail.The Housekeeping Director will complete waking rounds in the facility that will encompass all resident rooms, dining rooms, shower rooms, public bathrooms, closets, hallways, and all clean and soiled utility rooms to ensure proper cleaning. Concerns identified by the Director will be identified on housekeeping rounding logs. The Administrator will review the completed logs on a weekly basis to ensure that needed follow-up has been completed. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Resident mail received into the facility will be delivered to the residents /responsible parties immediately after receipt by the facility. Mailed that is deemed to be undeliverable will be appropriately logged by the Activity Director and an explanation will be provided as to why the mail could not be delivered. The Director will further ensure that all undelivered mail is locked away until such time that the mail can be received by the resident/responsible parties so designated as the proper recipient of the mail. The Administrator will conduct a weekly review of the mail delivery logs to ensure that resident mail	

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		02/12/2014

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

(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
			is properly delivered.The Administrator will, twice per month, complete a walking round with the Housekeeping Director to ensure the proper cleaning of the facility. The results of the rounds will be logged and reviewed in the daily morning meetings to allow for additional follow-up and review by the Interdisciplinary team. How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The mail delivery logs that are completed by the Activity Director and the housekeeping rounding logs completed by the Housekeeping Director are reviewed weekly by the Administrator. The Housekeeping and Activity logs will further be reviewed at the regularly schedule Quality Assurance Meeting (QA) for a period of three months and quarterly thereafter to ensure that compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings.Completion Date: March 14, 2014	
F000456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. 1). Based on observation and	F000456	F456What corrective action (s)	03/14/2014

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	interview the facility failed to assure a residents bathroom toilet would flush. This affected 1 of 19 resident rooms on the 200 unit. 2). Based on observation, interview and record reviews the facility failed to assure the large commodes in the dirty utility rooms were properly flushing for 1 of 5 commodes. 3). Based on observation and interview the facility failed to secure a cover-lid of an open sewer pipe of the bathroom located in the nurses station on the 200 hall. 4). Based on observation and interviews the facility failed to secure an electrical cord in the Main Dining room. This affected 1 of 1 Eco-lights (wall lighting unit) located in the Main Dining Room. Findings include: 1). On 2/11/14 at 1:45 p.m. to 2:15 p.m., a tour of the 200 unit was conducted. The bathroom toilet of room #216 would not flush. On 2/11/14 at 2:16 p.m., an interview was conducted with the Maintenance Supervisor indicating he had no knowledge of this and did		will be accomplished for those residents found to have been affected by the deficient practice? The toilets on the 200 unit and in the soiled utility room have been repaired and both toilets do properly flush.The cover lid for the open sewer pipe across from the 200 unit nurses' station has been obtained and properly fitted by the facility's Maintenance Director.The echo lighting and the attached electrical cord in the main dining room have been removed and are no-longer a concern.The bathroom toilet in Room 216 and the large toilet in the soiled utility/mechanical storage on the 200 unit have been repaired and do now properly flush.The loose lid cover on top of the bathroom plumbing hole located near the nursing station on the 200 unit has been properly secured by the Maintenance Director and the lid is no-longer loose fitting.The Maintenance Director has been in- serviced by the Administrator that daily rounds in the facility will be completed by the Maintenance Director and further that the Maintenance Director will complete performance maintenance logs to ascertain repair needs in the facility. The Director was finally in-serviced that work request logs are to be made available by the Director on all nursing units in the facility.The Maintenance Director and the Administrator did in-service all	

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	not know why it was not working nor how long it had been not flushing. 2). On 2/11/14 at 1:45 p.m. to 2:15 p.m., a tour of the 200 unit was conducted indicated the large toilet located in the dirty utility/ mechanical / storage room of the 200 unit was not flushing. The handle to the commode would depress, the commode would make an attempt to flush but a flush of the water would not complete. It was observed at this time that the water was not clear and was dirty. On 2/11/14 at 2:16 p.m. an interview was conducted with the Maintenance Supervisor indicating he was not aware that the commode was not flushing and indicated the staff of unit 200 used this for decontamination of soiled reusable linens and clothing. On 2/12/14 at 12:00 p.m., a record review was provided titled, " [name of plumbing service provider]. Customer: [Facility's name]. Date: 2/11/14. Room 154. Auger wash. Urinal pulled out and a cup and comb...." On 2/12/14 at 12:01 p.m., an interview was conducted with the		staff that work request logs are to be completed and forwarded to the Maintenance Director as facility repair needs are identified. How other residents having the potential to be affected by the deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will complete a walking round in the facility that will encompass all resident rooms, shower rooms, public bathrooms and all clean and soiled utility rooms in the facility to ensure that all toilets do properly flush and further to ensure that all toilets, sewer systems and facility hoppers are in good repair. The Director will further inspect facility lighting systems and attached electrical cords to ensure that all lighting and electrical cords are used safely throughout the facility. Concerns identified by the Director will indicated on the performance Maintenance logs. The Administrator will review the completed Maintenance logs on a weekly basis to ensure that needed follow-up is completed.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?The Administrator will, twice per month, complete a walking round with the Maintenance Director to inspect	

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		02/12/2014

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

(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
	acting-intern Administrator indicating that the large commode on the 200 unit located in the dirty utility room had been snaked and was now working properly. It was also indicated the facility had 5 of the large commodes located one on each unit. It was noted the overseeing of the maintenance and cleaning/ disinfecting of the large commode equipment was not clear. 3). On 2/11/14 at 1:45 p.m. to 2:15 p.m., a tour of the 200 unit was conducted. An observation was made of the bathroom located within the new nurse station indicating a loose lid cover on top of the open sewer plumbing hole. It was indicated by the Maintenance Supervisor that the lid should be secured to keep sewer gas from escaping into the living area of unit 200. 4). On 2/12/14 at 2:15 p.m. a tour of the Main Dining Room was conducted indicating wall-lighting unit referred to as an 'Eco-light' to be located approximately 8 feet up the wall. These were in the shape of an isosceles triangle with an electrical cord hanging the length of the wall and plugged into the standard electrical outlet. The light was warm		the maintenance of facility of hoppers, shower rooms, lighting systems, resident rooms, public bathrooms and all clean and soiled resident utility rooms. The results of the rounds will be logged and reviewed in the daily morning meeting to allow for additional follow-up by the Interdisciplinary Team. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?The Performance Maintenance rounds that are completed by the Maintenance Director and reviewed weekly by the Administrator will be further reviewed at the regularly scheduled Quality Assurance Meetings (QA) for a period of three months and quarterly thereafter to ensure that compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date: March 14, 2014	

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	to touch. The cord was not protected nor was it hugged securely to the surface of the wall yet draped down and outward. The cord was within easy reach of the residents in the main dining room. At 2:16 p.m., an interview was conducted with the acting-interim Administrator indicating the use of the Eco-lighting was not clear and believed to no longer be in use. At 2:17 p.m., an interview was conducted with the Maintenance Man indicating he was not sure to what the Eco-lights were for, why the cord was not anchored to the wall. On 2/12/14 at 2:50 p.m., an interview was conducted with the Regional Director Officer for the Facility in relations to the Maintenance functions of responsibility indicating it was the maintenance job responsibility for maintaining the functioning of the toilets, on-going construction safety concerns and electrical concerns including safety. This federal tag relates to Complaint #IN00144084. 3.1-19(bb)			

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1). Based on observations and interviews, the facility failed to repair holes in the interior of residents rooms on the 200 unit. This affected 8 of 19 resident rooms. 2). Based on observations, interviews and record review, the facility failed to clean a closet used for dirty utility, a closet used for activities and a closet on the assisted dining room. This included 3 of 5 units in the facility. (Unit 200, 300 and 400.) Findings included: 1). On 2/11/14 at 1:45 p.m. to 2:15 p.m., a tour of the 200 unit was conducted and the following items were observed:	F000465	F465What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? The holes in the wall between the resident rooms and the bathroom have been repaired in room #s 202, 203, 204 and the holes in the interior outside wall of Room 204 have been repaired.The holes in the interior wall of the resident's bathroom door of Room 206 have been repaired.The hole in the wall between the resident room and the bathroom in Room 215 and the holes on the interior outside wall in the room have been repaired.The holes in the interior–outside walls of Rooms 216 and 217 have been repaired.The hole in the wall between the resident room and the bathroom in Room 219 and the holes on the interior-outside wall of Room 220 have been repaired.The large toilet	03/14/2014

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	Room #202 had a hole in the wall in the wall between the resident room and bathroom. This was located by the head of the bed on the A side of the room. Room #203 had holes on the interior- outside wall. This was located on the Bed B side of the room. Room #204 had a hole in the wall in the wall between the resident room and bathroom. This was located by the head of the bed on the A side of the room. There were holes on the interior- outside wall. This was located on the Bed B side of the room. Room #206 had a hole on the interior side of the resident's bathroom door. Room #215 had a hole in the wall in the wall between the resident room and bathroom. This was located by the head of the bed on the A side of the room. There were holes on the interior- outside wall. This was located on the Bed B side of the room. Room #216 had holes on the interior- outside wall. This was		containing discolored water/ fluid in the locked closet on the 200 unit with signage of, “Mechanical Closet” has been cleaned. The walls in the room have been cleaned and the scuff marks in the walls and gouges on the walls and flooring have been repaired and painted.The Activities closet on the 300 unit indicating locked door knob has been cleaned. The lock on the door has been repaired and the lock does now secure the closet. The closet has been re-arranged as to ensure organization. The Assisted Dining Room on the 400 unit that contained accordion style bi-fold doors has been cleaned. The closet in the room has been cleaned and the doors to the closet have been repaired to ensure that proper tracking of the doors is ensured. The adult’s coat and other items in the closet have been removed. The two door cabinet containing hot/cold water has been cleaned. The eye wash station and the metal paper towel and soap dispenser have all been cleaned. The dirty caulk around the edges of the countertop and wall has been removed. The pest trap under the cabinet has been removed.The scuffed walls and gouged-out walls and floor tiles in the Assisted Dining Room have been repaired.The dining room tables are no-longer displaced and have been cleaned. The tables have been stabilized as to avoid wobbly structures. The	

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	located on the Bed B side of the room. Room #217 had holes on the interior- outside wall. This was located on the Bed B side of the room. Room #219 had a hole in the wall in the wall between the resident room and bathroom. This was located by the head of the bed on the A side of the room, There were holes on the interior- outside wall. This was located on the Bed B side of the room. Room #220 had holes on the interior- outside wall. This was located on the Bed B side of the room. On 2/11/14 at 2:16 p.m. an interview was conducted with the Maintenance Supervisor indicating repair work was being conducted on the outside walls in the residents rooms yet was not committed to knowing what the holes on the wall between Resident Bed A and the Resident bathroom nor the interior Resident bathroom door of room #206. 2). On 2/11/14 at 1:55 p.m. a tour of		window blinds have been cleaned and are in good repair. The work schedules of the contracted housekeepers have been reviewed by the Administrator and the contracted Housekeeping Accounts Manager. The housekeeping employee work schedules have been adjusted to allow for cleaning of facility closets and soiled utility rooms. The contracted Housekeeping Director/ contracted housekeepers have also been in-serviced by the contracted Accounts Manager and the Administrator as to the specific job duties of the housekeepers and the floor technicians have been in-serviced as to facility floor care responsibilities. The Maintenance Director has been in-serviced by the Administrator that daily rounds in the facility will be completed by the Maintenance Director and further that the Maintenance Director will complete performance maintenance logs to ascertain repair needs in the facility. The Director was finally in-serviced that work request logs are to be made available by the Director on all nursing units in the facility. The Maintenance Director and the Administrator did in-service all staff that work request logs are to be completed and forwarded to the Maintenance Director as facility repair needs are identified. How other residents having the potential to be affected by the	

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	the 200 unit locked closet with signage of 'Mechanical Closet' was conducted. The following items were observed: A large toilet was dirty and holding a 3/4th's bowl full of dirty-discolored water-fluid. It was noted to be used for de-contaminating the linen/clothing prior to sending to the laundry. The walls were in need of cleaning and painting and there were scuff-marks and gouges on the walls and flooring. On 2/11/14 at 2:15 p.m., a tour was conducted of the Activities Closet on the 300 unit indicating a locked door-knob that was not securing the closet. Upon observation of the closet, it was noted to be overall dirty; accumulated trash and debris were around the edges of the flooring including old cigarette butts, summer activity equipment, trash, dirt and an unopened envelope of Resident mail. The closet was disorganized and walls and flooring were in need of repairs. On 2/11/14 at 3:00 p.m., a tour was conducted of the Assisted Dining Room on the 400 unit indicating a closet area with accordion-style bi-fold doors that were off the track		same deficient practice will be identified and what corrective action (s) will be taken?All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director and Housekeeping Director will complete walking rounds in the facility that will encompass all resident rooms, dining rooms, shower rooms, public bathrooms, closets, hallways and all clean and soiled utility rooms, to ensure proper cleaning and needed maintenance repair work. Concerns identified by the Directors will be indicated on the performance maintenance logs by the Maintenance Director and on the housekeeping rounding logs by the Housekeeping Director. The Administrator will review the completed logs on a weekly basis to allow for needed follow-up and will further review the housekeeping work schedules to ensure that adequate staffing is scheduled to allow for proper cleaning of the facility.What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur?The Administrator will, twice per month, complete walking rounds with both the Housekeeping and Maintenance Directors to inspect and ensure the cleanliness of the facility and to further to inspect and ensure the proper repairs and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155103	A. BUILDING 00 B. WING	02/12/2014

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

(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
	to keep them firmly supported against the wall. The closet was opened and the floors were dirty, littered with debris, disorganized items, an adults coat and varying items in proximity of the dining area of the residents. It was also noted a handwashing station including a 2-door bathroom cabinet unit with a basin and hot/cold water, a metal paper towel dispenser and soap dispenser. It was observed to be dirty, build of soap residue and old, dirty caulk around the edges of the countertop and the wall. The doors to the unit were unlocked and observed to have a pest-trap for pest extermination purposes. This was in reach of residents and used for handwashing of staff during meals. The Assisted Dining Room had dirty flooring, scuffed walls and gouged out areas on the walls and floor tiles; the dining room tables were displaced around the area; unclean and grimy to touch and many were wobbly and unstable when placing items on the surface. The window blinds were dirty and in need of care. On 2/11/14 at 3:01 p.m., a record review was conducted of the Housekeeping/ Laundry Schedule for staffing including the following:		maintenance needed in the facility. The results of the rounds will be logged and reviewed in the daily morning meetings to allow for additional follow-up by the Interdisciplinary Team. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Performance Maintenance rounds logs completed by the Maintenance Director and the Housekeeping Rounds logs and Housekeeping contracted employee schedules that are completed by the Housekeeping Director, will be reviewed by the Administrator on a weekly basis. The Quality Assurance Committee (QA) will review the housekeeping logs and work schedules, and the maintenance logs for a period of three months and quarterly thereafter to ensure that compliance is maintained. The QA committee will make recommendations for needed changes and/or follow-up. The Administrator attends all regularly scheduled QA meetings. Completion Date:March 14, 2014	

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	"...coverage of housekeepers from 8 a.m. to 2:00 p.m. daily including weekends..." all units are scheduled daily and on weekends." A record review of the job descriptions were reviewed indicating the housekeepers tasks as: " Morning Walk, Front Lobby, Living Room, dining room, Nurses Station, med Room, Porch Area, Deep Clean, Deep Clean, Room 202, 204, 206, 208, 210, 210, 214, 216, 218, 220, 222, 219; Lunch. Dining room, Room 217, 215, 209, 207, 205, 204. Walk with Manager." "Job title: Light Housekeeper.... also so discharge cleaning and may also be called on for utility work in any area of the building... Supervised by: Account Manager...." "Job title: heavy Housekeeper...also do project work including but not limited to stripping and refinishing, carpet shampooing, wall washing, etc....Supervised by: Account Manager." On 2/12/14 at 12:15 p.m., an interview was conducted with the District Manager of Housekeeping indicating the 'Account Manager' of the facility was not on location at time of the survey. It was indicated that the Housekeeping and Laundry			

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	Services are a contract-provided service. It was noted that the cleaning schedule did include resident room cleaning on a daily basis and in a, "perfect world the walk with the managers are suppose to happen on a daily basis...." It was also noted that it was not the responsibility of the housekeeping department to keep the closet areas clean. On 2/12/14 at 12:20 p.m., an interview was conducted with the Regional Director of Operations for the facility in regards to the responsibility of cleaning the closet areas of the facility. A procedure was provided titled,"Cleaning Methods (Housekeeping). Policy. [Name of facility's corporation] centers will follow the procedures for cleaning located in the Housekeeping Manual. Each center will develop a cleaning schedule.... Surfaces in and around toilets in resident's rooms...." It is noted that the policy/procedure provided does not include areas outside of resident areas. An interview was conducted with the Regional director of Operations for the facility indicating, "... the large toilets in the mechanical rooms/ dirty			

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	storage on unit 200 are the Houskeepings responsibility... it would be public plumbing fixture...." On 2/12/14 at 12;22 p.m., a record review was provided of the handbook titled,"Bloodborne Pathogens Employee Handbook (Name of Housekeeping/ Laundry Contracted Service provider)," on page 5 of the handbook,"...Important. Any equipment or furniture that is contaminated with visibly large quantities of blood or other bodily fluids will be referred to nursing personnel of the client facility for decontamination and will not be handled by employees of the (name of the Housekeeping/ Laundry Contracted Service provider)...employees are only to clean previously decontaminated areas or small areas requiring clean up...." On 2/12/14 at 12:25 p.m. to 1:15 p.m., interviews were conducted with the Housekeeping Staff and the following were noted below: At 12:00 p.m., Staff #20 was interviewed indicating it was the responsibility of the 200 unit housekeeper to work 6 hours a day			

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	including a 30 minute break leaving a 5 1/2 hour shift for cleaning. Staff #20 indicated the job did not include cleaning the closets or mechanical/ dirty utility rooms. It was indicated that on a routine basis the 200 hall unit was only partially cleaned due to the addition of the job responsibility of cleaning the front office area, restrooms, staff breakrooms and odd jobs prior to the assignment for the 200 unit. It was indicated,"... at 8 I begin by picking up after 3rd shift then the breakfast dining room area because breakfast takes a lot of our time. Then, I leave the unit and clean the front desk area because the first impression of the facility is the front area and they [managerial staff] want it looking real nice... then, my lunch break at 11 a.m.. Then I tour the 200 unit and begin the residents rooms and then I have to clock out by 2, which really doesn't give me a lot of time to finish the rooms... sometimes, I can miss a room for a good day, but if someone tells me that something needs to get done, I can get to it right away...." At 12:30 p.m., Staff #21 was interviewed indicating it was the responsibility of the 300 unit housekeeper to work the same as mentioned above. Staff #21			

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	indicated the job did not include cleaning the closets or mechanical/ dirty utility rooms. It was indicated that the job of the 300 unit housekeeper was often difficult to complete in a days time due to the procedure of not allowing the housekeepers cart on the unit at the same time as the food tray carts. The housekeeping cart was to be in the housekeepers closet during that time. it was indicated, "... we [the facility] have to do 2 deep cleanings instead of 1 and those take a lot of time... then, when breakfast or lunch is being served, the housekeepers cart has to be kept 10 feet away from the lunch carts... often the lunch carts are left on the unit long past time, and that stops me from being able to complete the housekeeping work, and then I have to take my 30 minute break and clock out by 2 p.m.... yes, I leave work left undone, not because I don't try, it's just hard to get done...." At 12:45 p.m., Staff #22 was interviewed indicating it was the responsibility of the 400 unit housekeeper to work the same as mentioned above. Staff #22 indicated the job did not include cleaning the closets or mechanical dirty utility rooms. It was indicated			

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 02/12/2014
NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614	

(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
	that this housekeeper had been employed less than a 2 weeks and had been assigned to work the 200 unit after 3 days on another unit. It was indicated Staff #22 was not shown any specific cleaning assignments and did the best she could. At 12:50 p.m., Staff #23 was interviewed indicating it was the responsibility of the 500 unit housekeeper to work the same as mentioned above. Staff #23 indicated the job did not include cleaning the closets or mechanical dirty utility rooms. At 12:55 p.m., Staff #24 was interviewed indicating to be learning, "... on the fly..." in regards to the job responsibilities of cleaning. It was also indicated that there was not training on cleaning the 200 unit,"... no, nothing different... we just go in there and wipe stuff down and do what we need to do... the Account Manager is suppose to do a walk behind, but I've not seen that...." At 12:56 p.m., an interview was conducted with the Activities Director indicating the responsibility for keeping the closet areas clean was unknown.			

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 02/12/2014

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

(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
	This federal tag relates to Complaint #IN00144084. 3.1-19(f)			