

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  05/18/2012
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NAME OF PROVIDER OR SUPPLIER  IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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F0000	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00106237 and IN00105644 completed on 4/4/12.</p> <p>Complaint IN00106237- Not Corrected.</p> <p>Complaint IN00105644- Corrected.</p> <p>Survey dates: May 18, 2012</p> <p>Facility number: 000042 Provider number: 155103 AIM number: 100291540</p> <p>Survey team: Sandra Haws, RN- TC Shannon Pietraszewski, RN</p> <p>Census bed type: SNF/NF: 136 Total: 136</p> <p>Census payor type: Medicare: 11 Medicaid: 103 Other: 22 Total: 136</p> <p>Sample: 6</p> <p>This deficiency reflects State findings</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	cited in accordance with 410 IAC 16.2.  Quality review completed on May 25, 2012 by Bev Faulkner, R.N.				

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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. (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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F0441	It is the practice of this facility that residents will be free of infections	06/20/2012			

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	<p>2 of 4 shower rooms and equipment was kept clean and sanitary and free from the spread of potential infection related to 1 of 4 shower chairs observed with a smear of brown feces, and for 1 of 2 shower beds observed with brown feces and food particles, a ball of hair observed on 1 of 4 shower room floors and a moldy shower curtain observed for 1 of 4 shower rooms observed for cleanliness. This deficient practice has the potential to affect all 86 residents residing on these units. This directly affected Resident # 100</p> <p>Findings include:</p> <p>1. During a tour of the 400 unit shower room on 5/18/12 at 9:45 a.m., accompanied by RN # 5 the following was observed:</p> <p>A shower bed was observed to have a large blue plastic cushion with half dollar sized holes in it to allow water to pass through. The cushion was lifted to expose a white mesh support attached to the frame which held the large blue cushion. The white mesh was observed to be laden with brown feces and food particles from one end of the mesh to the other. The bottom side of the blue cushion was covered with feces and food particles. The bottom rail of the shower bed was observed to have a soiled wound dressing</p>		<p>through an Infection Control Program. Resident #100 had no negative outcome and care plan was reviewed and updated as necessary to reflect current status.</p> <p>Residents residing in facility will be addressed by facility Policy and Procedure.</p> <p>"Directed In-Service Training for all nursing staff and housekeeping staff regarding the facilities policy and procedures related to infection control primarily, cleaning of shower areas and shower equipment to be completed by June 20, 2012.</p> <p>Administrator and Housekeeping manager will perform daily rounds on shower room cleanliness for four weeks, 3 times per week for 2 weeks, 2 times per week for two weeks and monthly thereafter.</p> <p>Nurse Managers will perform daily rounds of shower rooms on evening shift and day shift for four weeks, 3 times per week for 2 weeks, 2 times per week for two weeks and monthly thereafter.</p> <p>All findings will be reviewed at monthly QPI meeting monthly for 3 months and then quarterly thereafter to determine if further education and/or further monitoring is needed. Any identified non-compliance will result in one</p>		

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	<p>stuck to the rail of the shower bed which was observed to be dated 5/7/12.</p> <p>A large ball of hair the size of a baseball was observed in the middle of the shower room floor.</p> <p>During an interview with RN # 5 at that time regarding who was responsible for ensuring the equipment was sanitized, she indicated the housekeeping department was responsible for cleaning along with staff when they are done showering a resident.</p> <p>While continuing the tour of the 400 unit on 5/18/12 at 10:15 a.m., RN #5 identified Resident # 100 as a resident who uses the shower bed for his showers due to his severe contractures.</p> <p>Resident # 100's record was reviewed on 5/18/12 at 12:05 p.m. The resident's record indicated diagnoses of, but not limited to; respiratory failure, status post tracheostomy, MRSA, (Methicillin-resistant Staphylococcus aureus), and expressive aphasia (difficulty communicating).</p> <p>The resident's annual MDS (Minimum Data Set) assessment, dated 2/22/12, indicated the resident's cognition was severely impaired. He required a Hoyer</p>		<p>on one re-education including progressive disciplinary action up to and including termination.</p>				

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	<p>lift for transfers and needed total assistance with bathing. The MDS indicated he was frequently incontinent of bladder and bowel function. The resident's record indicated he had a wound to his left hip requiring a dressing.</p> <p>The resident's plan of care, dated 2/29/12, indicated " ADL(activity for daily living) Mobility: Plan of Care" indicated " Assist, encourage, provide per resident preference: Shower, Bed bath ...."</p> <p>2. During a tour of the 500 unit shower room on 5/18/12 at 10:30 a.m., accompanied by RN # 6, the following was observed:</p> <p>A shower chair was observed to have a smear of brown feces on the seat area of the shower chair.</p> <p>The entire bottom of the blue shower curtain was observed to have black mold all along the bottom of the shower curtain 8 inches up from the bottom.</p> <p>A rolled piece of a gauze- type material was observed in the shower area.</p> <p>3. During a tour of the 100 unit shower room on 5/18/12 at 11:00 a.m., accompanied by RN # 7, a shower chair was observed to have a used nicotine</p>			

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	<p>patch stuck to the side of the shower chair.</p> <p>This deficiency was cited on 4/4/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to Complaint IN00106237.</p> <p>3.1-18(a)</p>			
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