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| 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 01/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER TIPTON HOUSE | STREET ADDRESS, CITY, STATE, ZIP CODE 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750 |
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| R000000 | <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: January 9 and 10, 2014</p> <p>Facility Number : 003376 Provider Number: 003376 AIM Number: N/A</p> <p>Survey Team: Kim Davis, RN,TC Shelly Reed, RN</p> <p>Census Bed Type: Residential: 27 Total: 27</p> <p>Census Payor Type: Other: 27 Total: 27</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p> | R000000 | | |

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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| R000147 | <p>410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents could exit one of two north fire doors.</p> <p>Findings include:</p> <p>Upon entrance to the facility on 1/9/14 at 9:30 a.m., the northeast fire door exit was observed. There were several strips of black and yellow "caution" tape secured on the walls going side to side in front of the door. Two "Stop signs" hung from the tape. Snow had not been removed outside the door from three feet out the door and around the building blocking a fire exit.</p> <p>The facility Evacuation Plan hung in picture frames close to the door. The Evacuation Plan indicated this door was in deed a fire exit.</p> <p>During the Initial Tour on 1/9/14, between 10:00 a.m. and 10:30 a.m., Qualified Medicine Aide (QMA) # 1, indicated 13 of the 27 residents in the facility had confusion.</p> | R000147 | <p>R-147 Facility staff shall not block fire doors in the building. The maintenance tech shall walk through the building on a daily basis to ensure that fire doors are free of obstructions, and will document findings on his daily walk-through checklist. Administrator shall review Maintenance Daily Walk-through Checklist along with Quality Assurance Checks to ensure compliance with requirements. Date of Completion: 01/09/2014 The facility's snow removal company was notified to clear the area directly behind the building (up to 50 feet away from the building), to permit safe evacuation in the event of an emergency. When snow is present, Administrator shall ensure that any snow behind the building has been removed up to 50 feet away from the building. The corrective action shall be monitored as necessary (based on weather events). Date of Completion: 01/10/2014</p> | 01/10/2014 | | | |

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| | <p>The administrator was interviewed on 1/9/14 at 3:00 p.m. The administrator indicated staff had purposely hung the caution tape and stop signs on the fire exit door. She indicated, the resident (Resident #K) in the room closest to the door had been exit seeking. The administrator indicated, the resident was confused and wandered about the facility looking for a door to get outside. The administrator went on to say, the resident had gone to that particular fire door closest to her room and pushed on the door. The administrator indicated the facility evacuation route, was out the fire door and around the building. She indicated the snow was in the walk way. The administrator further indicated, she could ask the snow removal company to clear the evacuation area but had not done so.</p> <p>The clinical record of Resident # K was reviewed on 1/10/14 at 10:45 a.m. The record indicated the resident's diagnoses included, but were not limited to, dementia, depression, and osteoporosis.</p> <p>A nurse note dated 9/15/13, indicated, "... exit seeking at back</p> | | | | | | |

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| R000214 | <p>door, redirected... uses walker...".</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents received an evaluation prior to admission or semi-annually for 2 of 7 sampled residents (Resident C and H) and semi-annually for 1 of 7 sampled residents. (Resident E)</p> <p>Findings include:</p> <p>During clinical record review on 1/9/14 at 1:00 p.m., Resident (C) was admitted to the facility on 1/13/13. During record review, Resident (C) did not receive a pre-admission evaluation or the following semi-annual evaluation.</p> <p>During clinical record review on 1/10/14 at 10:30 a.m., Resident (H) was admitted to the facility on 10/31/11. During record review,</p> | R000214 | <p>R-214 Wellness Director shall complete evaluations PRIOR to resident's admission, and evaluations shall be updated at least semi-annually and with a known change in condition.</p> <p>Administrator shall monitor the Wellness Director's completion of evaluations prior to resident's admission by auditing resident files to ensure compliance with this requirement. Date of Completion: 02/10/2014</p> | 02/10/2014 |

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| | <p>Resident (H) had not received the most recent semi-annual evaluation.</p> <p>During clinical record review on 1/9/14 at 2:40 p.m., Resident (E) was admitted to the facility on 3/19/03. During record review, Resident (E) did not receive the most recent semi-annual evaluation.</p> <p>During an interview on 1/9/14 at 3:30 p.m., the Wellness Director indicated he was behind on completing approximately 10 residents for their semi-annual evaluation. He indicated he was unable to find a semi-annual evaluation evaluation for Resident (C) or Resident (H). He indicated Resident (E) should of had a semi-annual evaluation done October of 2013.</p> | | | |

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| R000217 | <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on observation, record review, and interview, the facility failed to obtain psychological services for one of one resident with a need for psychological services in a total sample of seven (Resident # D).</p> | R000217 | R-217 The Wellness Director, upon identifying a need for additional services such as the need for psychological evaluation and/or services, shall refer residents for subsequent necessary evaluations as the need arises. Resident service plans shall be updated according to changes and/or additions and | 01/15/2014 | | | |

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| | <p>Findings include:</p> <p>The Initial Tour was conducted on 1/9/14 between 10:00 a.m. and 10:30 a.m. with Qualified Medicine Aide (QMA) # 1. During the tour, QMA #1 indicated Resident # D was recently admitted to the facility and displayed "mood swings".</p> <p>The clinical record of Resident # D was reviewed on 1/9/14 beginning at 2:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, dementia, diabetes, and arthritis.</p> <p>The physician orders, dated 12/22/13, included, "Resident may have psychological evaluation and treatment as indicated". There was no other of mention of the psychological evaluation found in the clinical record.</p> <p>A nurse note, dated 1/5/14 at 4:00 a.m., indicated the resident told the Certified Nursing Assistant (CNA) she wanted to kill herself and she knew how to do it. The CNA did phone the Director of Nursing (DoN) and 15 minute checks were initiated.</p> <p>During an interview with QMA # 1, on 1/10/14 at 8:15 a.m., the QMA</p> | | <p>resident and/or POA shall review/sign and date services plans as changes/additions are made. Administrator and Wellness Director shall monitor resident needs according to reports by staff, residents and/or resident families with regard to changes in resident condition (mental/physical) that may indicate further evaluation and subsequent treatment provided by a third party (i.e., psychological evaluation), and shall arrange for evaluation as the need arises to ensure compliance with this requirement. Date of Completion: 01/15/2014</p> | | | | |

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| | <p>indicated the resident had gone to the hospital early on 1/10/14 due to a suspected low blood sugar.</p> <p>The DoN was interviewed on 1/10/14 at 10:00 a.m. The DoN indicated the psychologist had been booked up, then on vacation, so he was unable to come and evaluate Resident # D. The DoN indicated he had thought about the resident going out to a psychologist. The DoN further indicated Resident # D had no psychological evaluation after the statement of suicide on 1/5/14 as the physician orders dated 12/22/13 had stated.</p> | | | |