

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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TIPTON HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750
--	--

(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
R000000	<p>This visit was for the Investigation of Complaint IN00135141.</p> <p>Complaint IN00135141: Substantiated at R0064.</p> <p>Survey date: September 5, 2013</p> <p>Facility number: 003376 Provider number: 003376 AIM number: N/A</p> <p>Survey Team: Shelley Reed, RN TC</p> <p>Census bed type: Residential: 28 Total: 28</p> <p>Census payor type: Other: 28 Total: 28</p> <p>Sample: 3</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.

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER  TIPTON HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750			
(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			
R000064	<p>410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents' property was protected against theft. This deficiency affected 3 of 3 residents interviewed about personal property (Resident B, C and D).</p> <p>Findings include:</p> <p>During an interview on 9/5/13 at 9:30 a.m., Resident B indicated she had some money missing from her lock box in her room. She indicated she reported the missing money to the DoN (Director of Nursing), but soon after she reported the incident, the money was found back in her lock box.</p> <p>A reported incident, dated 8/20/13, was reviewed. The incident report indicated Resident C had 102 missing Tramadol tablets (a medication used to treat moderate to severe pain). The report indicated during narcotic count, a 300 count bottle of Tramadol</p>	R000064	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. R 043 410 IAC 16.2-5-1.2(q)(1-2) Residents' Rights - Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? The affected residents and their responsible parties have been re-educated on company policy pertaining to securing of medications and/or valuables within their apartment. The	09/05/2013			

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER  TIPTON HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750			
(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			
	<p>only contained 198 pills. 102 Tramadol from the bottle were missing. Two additional reports related to misappropriation of property were also reviewed. The reports were dated 8/27/13 and 8/28/13.</p> <p>During an interview on 9/5/13 at 10:30 a.m., the Health Facility Administrator and the DoN indicated Resident C was missing 102 Tramadol from the narcotic box. The DoN indicated he was unsure of when the last correct count of the Tramadol was done. He indicated the local police department collected the information from the staff involved and were continuing the investigation. He indicated the nursing staff provided statements, indicating they were not correctly counting the narcotics. The DoN also indicated the missing money from the report, dated 8/28/13, was substantiated by the facility. The report, dated 8/27/13, was found to be unreliable related to the residents ability to recall detail.</p> <p>During an interview on 9/5/13 at 10:45 a.m., Resident C indicated he was unaware he was missing 102 Tramadol. During the interview, Resident C's son came to visit. Resident C's son indicated the facility</p>		<p>Residence Director ensured residents within the community have areas located within their apartment that are functioning properly so as to secure valuables and medications. Staff were re-educated as to our policy and procedure pertaining to misappropriation of resident property and narcotic counting. Staff were also re-educated to our policy and procedure regarding resident rights and misappropriation of resident property. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected. Residents have been educated and encouraged to keep their funds secure at all times. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director and/or Designee will conduct a random narcotic count audit weekly for a period of six months. The findings will be reviewed after a period of six months during the residence QA meeting in order to determine the need as to the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. How will the corrective action(s) be monitored to ensure the deficient practice</p>				

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 09/05/2013	
NAME OF PROVIDER OR SUPPLIER  TIPTON HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750			
(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			
	<p>did call him related to the missing Tramadol, but he had not yet told his father the medication was missing. He indicated he told the Administrator he would inform his father, but had not yet done so.</p> <p>During an interview on 9/5/13 at 12:45 p.m., Resident D indicated he had \$200.00 taken from his wallet approximately 6 months ago. He indicated he was also missing a digital camera and a half of a jar of change. He indicated he reported the missing items from his room to the old Administrator, but received no follow up. He indicated he always kept his door locked and was unsure of how the items were missing.</p> <p>During an interview on 9/5/13 at 1:05 p.m., QMA #1 (Qualified Medication Aide) indicated the narcotic drawer contained a large bottle of Tramadol for Resident C. She indicated the bottle had a piece of tape over the lid so staff would know the bottle had not been used. She indicated Resident C also had a small bottle and a card of Tramadol. QMA #1 indicated during narcotic count, they were not removing the tape and counting the pills in the large bottle. She indicated the staff were assuming the count was still 300.</p>		<p>will not recur, i.e., what quality assurance program will be put into place? The Regional team will also review the narcotic count during Quarterly visits to ensure continued compliance. By what date will the systemic changes be completed? 09/05/2013</p>				

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 09/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TIPTON HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 460 FORKS OF THE WABASH WAY HUNTINGTON, IN 46750
--	--

(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
	<p>During an interview on 9/5/13 at 2:10 p.m., LPN #2 indicated she was gone during the time the missing Tramadol was discovered. LPN #2 indicated the staff were not correctly counting the large bottle of Tramadol. She indicated the bottle had a piece of tape over the lid indicating the bottle had not yet been opened.</p> <p>Review of a current facility policy, dated 1/1/13, titled "Controlled Drugs Management" which was provided by the DoN on 9/5/13 at 1:30 p.m., indicated the following:</p> <p>"...III. At each shift change, or any time the keys must be handed off to another authorized person, the narcotics count should be verified by the oncoming and previous person. Each narcotic sheet should be verified with an actual count of the medications. The Narcotics Count Shift Change form should be signed by both the oncoming and previous shift staff member."</p> <p>This State Residential tag relates to Complaint IN00135141.</p>			