

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TIPTON PLACE	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
R 000 Bldg. 00	<p>This visit was for the investigation of complaint IN00169272.</p> <p>Complaint IN00169272-Substantiated. State deficiency related to the allegations is cited at F 9999.</p> <p>Survey Dates: March 31 and April 1, 2015</p> <p>Facility number: 003376 Provider number: 003376 AIM number: N/A</p> <p>Census bed type: Residential: 33 Total: 33</p> <p>Census payor type: Other: 33 Total: 33</p> <p>Sample: 3</p> <p>This deficiency reflects state finding cited in accordance with 410 IAC 16.2-5.</p>	R 000		

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 <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TIPTON PLACE	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
R 029 Bldg. 00	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to treat 1 resident (B) in a sample of 3 resident records reviewed with dignity and respect.</p> <p>Finding includes:</p> <p>On 3/31/15 at 10:20 a.m. interview with resident (B) indicated he did not feel well and was staying in his room today. Resident (B) was observed to be laying in his reclining chair with a C-Pap mask on his face. The resident indicated he does not get any sleep at night due to the staff waking him up every 1 to 2 hours. Resident (B) further indicated he wets the bed and that is why they wake him up. The resident indicated he wears briefs but the staff wake him up and make him walk to the bathroom.</p> <p>On 4/1/15 at 10:00 a.m. review of the clinical record for resident (B) indicated he had diagnoses including but not limited to Sleep</p>	R 029	<p>On behalf of Tipton Place, we respectfully request an informal dispute resolution and a reconsideration of the deficiency R-0029410 IAC 16.2-5-1.2(d) Resident Rights – Deficiency. We request an opportunity to present additional information in person as part of the informal dispute resolution process, in support of our position.</p> <p><u>Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d)</u> Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. We disagree with the citation related to this right based on the following: Resident B: Attachment A – Resident B's Therapy Note for follow-up visit on November 14, 2014 with Derek Paris, Psy.D, HSPP. "Upon entering his room, noted extreme urinary odor. He [Resident B] pleaded his inability to control flow until it was pointed out how angry he presented. Then he [decreased] those helpless statements." Dr. Paris "recommends trips home by family be made contingent upon his ability to stay clean and dry. Had recommended B&B program to him last visit. Today</p>	05/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TIPTON PLACE	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>Apnea, Chronic Diarrhea, Diabetes, Kidney Disease, Neuropathy, Urinary Retention, and History of Bladder Cancer. Review of the "Negotiated Service Plan Summary" dated 2/20/15 indicated the resident requires staff administer his medications, and assistance with bathing, dressing and toileting.</p> <p>Interview with staff on 3/31/15 starting 1:10 p.m. indicated the following:</p> <p>Staff #1 indicated other staff get angry and upset with resident (B). She indicated staff #4 has a voice that is aggressive, and she tells the resident he has to get up. She indicated the resident told her about staff #4 who wakes him up every hour through the night to use the bathroom and he is tired of her being so mean and mistreating him.</p> <p>Interview with Staff #5 indicated the resident had told her "staff #4 is on me" for wetting. Further interview with staff #5 indicated she felt the resident felt too much pressure from staff #4, and she felt staff #4 does not know how she presents herself. Staff #5 was</p>		<p>asking AL staff to help w/a 2-hour B&B program by asking him on every even # hour to take himself to the toilet." "Remindhim you're trying to help him become successful in order that he might be able to visit his farm & dog." "Okay to talk with family about alternative placement if he is not successful in efforts. It may well be he may require health care at this point." <i>As indicated above, staff was following a physician's recommendation with regard to the 2-hour B&B plan, and Resident B agreed with the plan, which would ultimately help him to achieve a goal of going home to visit his farm and dog.</i> R-029 – Resident Rights</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Staff will not enter "Resident B's" room during the night to offer to help him to the bathroom, as "Resident B" feels this is too disruptive to his ability to sleep and feel rested during the day, though "Resident B" will be assured we will assist as here requested. Staff will abide by "Resident B's" stated preferences with regard to having assistance specific to his bowel / bladder incontinence. -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; Staff will receive education</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2015	
NAME OF PROVIDER OR SUPPLIER TIPTON PLACE				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>queried how staff #4 presents herself and she responded "harsh."</p> <p>On 3/31/15 at 3:00 p.m. during the daily exit conference with the facility, the Executive Director (ED) and Care Service manager (CSM) were informed resident (B) had complained about being awakened every 1 to 2 hours during the night to be toileted. The ED stated "Resident (B) sits in BM (bowel movement) and urine and then calls people to clean him up. Resident (B) is lazy and he is not living up to his potential and he is obstinate. He wets and has BM on purpose. Did you smell his room?"</p> <p>On 4/1/15 at 10:05 a.m. staff #3 was queried about the care needs of resident (B). She indicated third shift staff usually get him dressed in the morning between 5:30 a.m. and 5:45 a.m. She indicated staff do his laundry, take out his trash and do housekeeping. She further indicated the resident needs assistance with bathing, dressing and toileting. Staff #3 indicated the resident attempts to dress himself but has trouble putting on his shirt and has trouble getting his pants and shoes on. Further interview indicated the resident</p>		<p>regarding Resident Rights to ensure that Resident's rights are being protected, and that resident preferences are followed. This in-service occurred on 4/15/15, provided by the Regional Director of Care Services. -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Residents will be asked their preferences prior to completion of staff task sheets to ensure that tasks specific to residents comply with their preferences. -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; and Task Sheets will be reviewed by Care Service Manager or designee weekly for needed updates to Resident Care. Task Sheet updates are discussed in Morning Stand Up Meeting. -By what date the systemic changes will be completed. Systematic changes will be completed by May 17, 2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TIPTON PLACE	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>apologizes to her for his need for care but she tells him it is ok we are here for you. Staff #3 indicated she felt the resident gets the impression that people get upset with him and it makes him feel bad.</p> <p>On 4/1/15 at 10:00 a.m. interview with staff #4 indicated she works first shift but had worked third shift for about 8 weeks. Staff #4 was queried about the care needs of resident (B) and she indicated we clean his toilet after he goes. Resident (B) has loose BM'S and goes all over the bathroom toilet, wall and floor. Staff #4 indicated the resident dresses himself if he wants. She indicated about 90% of the time he will dress himself. Staff #4 was asked if when she worked third shift if she got the resident up to go to the bathroom during the night. She indicated they got him up every 2 hours. Staff #4 stated "resident (B) will poop in his chair..." Staff #4 indicate staff do not get the resident up every 2 hours now because he gets mad and screams. Staff #4 indicated she heard in the last week that they were not to get the resident up at night.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TIPTON PLACE	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>On 4/1/15 at 10:45 a.m. interview with the Care Service Manager (CSM) indicated resident (B) is assisted with showers, trash, laundry, housekeeping, meals, maintenance, dressing, grooming, medication administration, diabetic monitoring and insulin administration. The CSM indicated she talked to the resident about his increased level of care due to his incontinence and the resident agreed to be toileted every 2 hours. She indicated "shortly" he did not like it. She indicated the resident agreed to have the staff ask him if he needed to go to the bathroom and if he said no, the staff would leave. The CMS indicated the facility was not doing this anymore, only if the resident requested them to awaken him during the night. She was queried when they had quit awaking the resident every 2 hours through the night and she indicated "maybe the last 2 weeks."</p> <p>On 4/1/15 at 11:15 a.m. Resident (B) indicated the ED and CSM had came to his room yesterday before supper and stated "We are not going to, from now on, effective immediately, wake you up at night unless you ask." Resident (B)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2015	
NAME OF PROVIDER OR SUPPLIER TIPTON PLACE				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>stated, "I slept all night last night, I feel better."</p> <p>This state deficiency is related to complaint IN00169272.</p>						