

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 09/07/2016
--	---	---	---

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 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: September 6 and 7, 2016</p> <p>Facility Number: 003376 Provider Number: 003376 AIM Number: n/a</p> <p>Residential Census: 35</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on September 8, 2016.</p>	R 0000		
R 0120 Bldg. 00	<p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p>			

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 09/07/2016
--	---	---	---

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>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to ensure staff completion and documentation of required in-services for 2 of 7 employee files reviewed for completion of dementia, abuse, and resident's rights training. (QMA # 43 & LPN # 45)</p> <p>Findings include:</p> <p>Review of Employee Records began on 9/7/16 at 9:00 a.m. and indicated the</p>	R 0120	<p>1. QMA #43 will complete the required annual training on resident's rights, dementia and resident abuse on 9/30/2016. LPN #45 will complete the required annual training on resident's rights, dementia and resident abuse on 9/30/2016.</p> <p>2. Current residents have the potential to be affected by the alleged deficient practice.</p>	10/15/2016

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 09/07/2016
--	---	---	---

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 0121 Bldg. 00	<p>following:</p> <p>QMA #43's employment record did not indicate completion of required annual training on resident's rights, dementia, or resident abuse.</p> <p>LPN #45's employment record did not indicate completion of required annual training on resident's rights, dementia, or resident abuse.</p> <p>On 9/7/16 at 1:55 p.m., the Administrator in Training (AIT) indicated there was no annual education completed for QMA #43 or LPN #45.</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not</p>		<p>3. An in-service training calendar will be established to include state required training modules, including resident's rights, dementia and resident abuse, by 9/23/2016.</p> <p>4. The ED and/or designee is responsible for sustained compliance. Regional Directors will monitor quarterly to ensure ongoing compliance.</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 09/07/2016
--	---	---	---

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>had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review, the facility failed to ensure employees had second step TB testing for 2 of 5 employees whose records were reviewed, and annual TB testing done for 1 of 5 employees whose record was reviewed. (LPN#41, CNA#42, and QMA#43)</p> <p>Findings include:</p> <p>The employee files were reviewed on 9/7/2016 at 9:00 a.m. The following was found:</p> <p>LPN #41 was hired on 7/19/2016. The</p>	R 0121	<p>1. LPN #1 will receive a tuberculin skin test using the 2-step Mantoux method by 10/01/2016. CNA #42 will receive a tuberculin skin test using the 2-step Mantoux method by 10/01/2016.</p> <p>2. Current residents have the potential to be affected by the alleged deficient practice.</p> <p>3. The Care Services Manager and the Administrator in Training were in-serviced on Indiana Tuberculosis</p>	10/15/2016

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 09/07/2016
--	---	---	---

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>first step TB test was completed on 7/22/2016. There was no second step found in the employee file.</p> <p>CNA #42 was hired on 5/12/2016. The first step TB test was done on 5/15/2016. There was no second step found in the employee file.</p> <p>QMA #43 was hired 9/10/2014. The employee file indicated the most recent TB testing had been completed on 9/24/2014.</p> <p>During an interview with the Administrator in Training (AIT) on 9/7/2016 at 9:30 a.m., she indicated that she and the Director of Nursing (DON) were new and the previous DON and Administrator left the employee records "in a mess." AIT indicated there was no second step for LPN #41 and CNA #42. She further indicated there was no annual TB test for QMA #43. AIT then indicated they intended to "start over" with the TB testing for LPN #41 and CNA #42.</p> <p>The current, 7/1/2014, facility policy titled "TB TESTING" was provided by the Director of nursing (DON) on 9/7/2016 at 10:16 a.m. The policy indicated "I. TB testing will be completed per state regulations for</p>		<p>Screening requirements by the Regional Director of Care Services on 9/07/2016.</p> <p>4. The Care Services Manager is responsible for sustained compliance. The Executive Director and/or designee will review new hire files within three (3) days of hire to monitor for the First Step Tuberculosis skin testing completion, and again within three (3) weeks of hire to monitor for the Second Step Tuberculosis skin testing completion. The Executive Director and/or designee will review employee files annually prior to employee anniversary date to audit for annual Tuberculosis Testing completion. Audit results for new hires will be discussed in monthly QA meetings. The QA committee will determine if continued auditing is necessary based on three (3) consecutive months of full compliance. Annual monitoring will be ongoing.</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 09/07/2016
--	---	---	---

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 0214 Bldg. 00	<p>residents, staff and volunteers. See chart of state- specific TB testing requirements in the appendix of this guide...IV. Th Care Services Manager is responsible for conducting or arranging for Mantoux method TB tests."</p> <p>The undated document titled "TB TESTING REQUIREMENTS" was provided by AIT on 9/7/2016 at 10:20 a.m. The Document indicated the following: "...Indiana [staff requirements] 2-step. Step 1 on hire, step 2 1-3 weeks after step 1...Annual required...."</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 record review and interview, the facility failed to ensure semi- annual care evaluations were completed for 5 of 7 residents reviewed for care evaluations (Residents 2, 4, 5, 6, 8).</p> <p>Findings include:</p>	R 0214	<p>1. Care Services Manager will complete Wellness Baseline on Resident 2 by 9/26/2016. Care Services Manager will complete Wellness Baseline on Resident 6 by 9/26/2016. Care Services Manager will complete the Negotiated Service Plan (assessment) on Resident 4 by 9/26/2016. Care Services Manager will complete the Negotiated Service</p>	10/15/2016

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 09/07/2016
--	---	---	---

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>1. Review of Resident 2's clinical record began on 9/6/16 at 10:53 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, congestive heart failure, and pacemaker.</p> <p>Resident 2's clinical record indicated she had last had a "Wellness Baseline" assessment completed on 11/20/15. There was no further assessment in the resident's clinical record regarding Resident 2's physical health and function.</p> <p>2. Review of Resident 6's clinical record began on 9/7/16 at 9:00 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, anemia, and edema.</p> <p>Resident 6's clinical record indicated she had last had a "Wellness Baseline" assessment completed on 11/20/15. There was no further assessment in the resident's clinical record regarding Resident 6's physical health and function.</p> <p>On 9/7/16 at 10:02 a.m., the Director of Nursing (DON) indicated Resident 2 and Resident 6 had not had a semi-annual evaluation completed since November 2015. 3. The clinical record for Resident 5 was reviewed on 9/6/2016 at 10:40 a.m. The diagnoses included but were not limited to congestive heart failure,</p>		<p>Plan (assessment) on Resident 5 by 9/26/2016. Care Services Manager will complete the Negotiated Service Plan (assessment) on Resident 8 by 9/26/2016.</p> <p>2. Current residents have the potential to be affected by the alleged deficient practice.</p> <p>3. The Care Services Manager was in-serviced on completing the Wellness Baseline and Negotiated Service Plan upon admission, review 30 days after admission, quarterly and with a significant change in status by the Regional Director of Care Services on 9/1/2016.</p> <p>4. The CSM is responsible for sustained compliance. The Executive Director and/or designee will review five (5) charts weekly for four (4) weeks, then five (5) charts every other week for four (4) weeks, then five (5) charts monthly for four (4) months. The chart review will be discussed in the monthly Quality Assurance meeting. The Quality Assurance Team will determine if continued audit reviews are necessary after three (3) consecutive months of full compliance.</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 09/07/2016
--	---	---	---

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>hypertension and osteoporosis. The clinical record indicated the last semi-annual was done on 12/28/2015. No further assessment in the resident's clinical record regarding Resident 5's physical health and function was found.</p> <p>4. The clinical record for Resident 4 was reviewed on 9/6/2016 at 11:28 a.m. The diagnoses included but were not limited to anemia and heart murmur. The clinical record indicated the last semi-annual was done on 1/06/2016. No further assessment in the residents clinical record regarding Resident 4's physical health and function was found.</p> <p>5. The clinical record for Resident 8 was reviewed on 9/7/2016 at 8:30 a.m. The diagnoses included but were not limited to depression and dementia. The clinical record indicated the last semi-annual was done on 1/20/2016. No further assessment in the residents clinical record regarding Resident 8's physical health and function was found.</p> <p>During an interview with the AIT on 9/7/2016 at 11:23, she indicated there were no current semi annual assessments done for Residents 4, 5 or 8.</p> <p>Review of a policy titled, "RESIDENT ASSESSMENTS", dated 7/1/14 and</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 09/07/2016
--	---	---	---

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 0414 Bldg. 00	<p>provided by the DON on 9/7/16 at 10:16 a.m., indicated the following:</p> <p>"...I. As part of the pre-move-in process, and on an on-going basis, residents will be assessed using a variety of assessment tools...</p> <p>IV. At the time of a resident Care Plan review or update...the following tools will also be completed as applicable: ...Wellness Baseline...."</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation and interview, the facility failed to use proper hand hygiene during medication pass for 1 of 5 residents observed (Resident 9).</p> <p>Findings include:</p> <p>During medication pass observation on 9/7/2016 at 11:45 a.m., with LPN #40, the following was observed:</p> <p>LPN #40 used hand sanitizer prior to preparation of Resident 9's medication. LPN #40 then removed gum from her mouth with her bare hand and threw it in</p>	R 0414	<ol style="list-style-type: none"> LPN #40 was re-trained on 9/07/2016 by Care Services Manager on the policy regarding infection control, and proper hand washing. Current residents have the potential to be affected by the alleged deficient practice. Staff were re-trained on infection control procedures, including proper handwashing by the Care Services Manager on 9/28/2016. 	09/30/2016

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 09/07/2016
--	---	---	---

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>the trash can on the side of the medication cart. LPN #40 then wiped both hands on her pants, picked up the 30 ml cup holding Resident 9's medication and entered her room. Resident 9 was holding a bowl of dessert in her hands. LPN #40 removed the bowl from Resident 9's hands and poured the medication into the resident's hand. LPN #40 picked up a blue cup approached the sink, turned the faucet on and filled the cup and then handed it to Resident 9. No hand hygiene was observed during the medication administration observation.</p> <p>During an interview with LPN #40 on 9/7/2016 at 12:03 p.m., she indicated she realized after the medication administration that she had not re-sanitize her hands in any way after touching her gum. She further indicated she should not have put her hands into her mouth to retrieve the gum and she should have washed her hands after touching it.</p> <p>The current 7/1/2014, policy titled REVENTING TRANSMISSION OF INFECTION," was provided by the DON on 9/7/2016 at 1:30 p.m. The policy indicated "1. According to the CDC, handwashing is the most important infection control measure in our Enlivant communities...."</p>		<p>4. The CSM will be responsible for sustained compliance. The ED and/or designee will monitor staff, who are passing medications, by observing handwashing techniques for five (5) employees, five (5) days per week for four (4) weeks, then give (5) employees, three (3) days per week for four (4) weeks, then one employee per week for four (weeks). Audit results will be discussed during monthly Quality Assurance meetings. The QA committee will determine if continued routine auditing will be necessary based on three consecutive months of full compliance. Random monitoring will be ongoing.</p>	

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

PRINTED: 09/26/2016

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 09/07/2016
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	