

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 08/11/2016
--	---	---	---

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 the Investigation of Complaint IN00206126.</p> <p>Complaint IN00206126-Substantiated. State deficiencies related to the allegation are cited at R0241 and R0406.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: August 10 and 11, 2016</p> <p>Facility number: 003376 Provider number: 003376 AIM number: N/A</p> <p>Census bed type: Residential: 33 Total: 33</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on August 15, 2016.</p>	R 0000		
R 0036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency			

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 08/11/2016	
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			
Bldg. 00	<p>(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:</p> <p>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or</p> <p>(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on observation, interview and record review, the facility failed to notify the physician when a resident exited the locked facility (Resident Z). The facility also failed to notify the physician related to a new skin wound for 1 of 9 residents reviewed for skin concerns (Resident E).</p> <p>Findings Include:</p> <p>1. The clinical record for Resident Z was reviewed on 8/10/16 at 4:45 p.m. Diagnoses included, but were not limited to, non-Alzheimer's dementia, congestive heart failure, dementia and cardiomyopathy. Resident I was admitted to the facility on 6/30/16.</p> <p>Review of an Indiana State Department of Health (ISDH) reportable on 8/10/16 at 3:20 p.m., indicated on 7/18/16 at 5:45 a.m., Resident Z exited the building through the West doors.</p>	R 0036	<p>1. Resident Z is deceased. Resident E's physician was notified of the blister on 8/11/16 and documented in the clinical record. Resident E's family was notified of the blister on 8/11/16 and documented in the clinical record.</p> <p>2. Current residents have the potential to be affected by the alleged deficient practice.</p> <p>3. The CSM was re-trained on the Change of Condition policy by the Care Services Specialist on 8/15/16. The LPNs were re-trained on this policy by the CSM on 8/24/16.</p> <p>4. The CSM is responsible for sustained compliance. The ED and/or designee will monitor changes in condition requiring notification to resident physician and resident family. Changes of condition will be discussed during routine Stand-Up meetings to ensure</p>	09/10/2016			

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 08/11/2016
--	---	---	---

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>Review of Resident Service Notes on 7/18/16 at 10:45 a.m., LPN #4 documented the following: "Res [resident] alert, pleasantly confused. No further attempts to exit." The previous nursing note was dated 7/15/16 at 11:00 a.m.</p> <p>During a phone interview on 8/11/16 at 9:02 a.m., QMA (Qualified Medication Aide) #5 indicated Resident Z did exit the building on 7/18/16. She indicated the door alarm sounding was received through her paper. She indicated the resident was confused and was looking for a bathroom. She indicated herself and a CNA brought the resident back into the facility. She indicated he had just shut the door as they were walking to get him. She indicated she did not document any of the information in the nursing notes because she was a QMA, but she did fill out an "incident report." She indicated she made several attempts to contact the family, but did not make any attempt to contact the physician.</p> <p>There was no documentation in the clinical record regarding the physician being notified of the facility exit.</p> <p>2. The clinical record for Resident E was reviewed on 8/11/16 at 7:55 a.m. Diagnoses included, but were not limited</p>		compliance. Monitoring will be ongoing.	

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 08/11/2016
--	---	---	---

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>to, hypertension, dementia, hyperlipidemia and pacemaker.</p> <p>During an observation on 8/11/16 at 4:10 p.m., RN #1 and LPN #2 went to assess the current skin condition of Resident E. A nickel size blister was noted on the top right foot. The blister was red in color and had no drainage</p> <p>Review of the clinical record indicated on 8/1/16, a CNA reported to a nurse that a fluid filled blister was found on the top, right foot of Resident E. The blister measured 1.4 cm x 1.5 cm. The note indicated the information would be passed on to the next shift. There was no documentation in the clinical record regarding the physician or family being notified of the blister.</p> <p>Review of a current facility policy dated 7/1/14, provided by the RN #1 on 8/11/16 at 4:32 p.m., titled "CHANGE OF CONDITION" indicated the following:</p> <p>"I. The Care Service Manager, Healthcare Coordinator, or designee is responsible for responding to a resident's change of condition, making appropriate notifications, and putting appropriate interventions in place.</p> <p>...VI. The Care Service Manager should</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 08/11/2016
--	---	---	---

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 0042 Bldg. 00	<p>notify the physician and family in accordance with resident preferences and licensing requirements."</p> <p>410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.</p> <p>Based on observation and interview, the facility failed to have the survey results accessible for residents and guests to review for 2 of 2 days of observation. This deficiency had the potential to impact 33 of 33 residents residing in the facility. (8/10/16 and 8/11/16)</p> <p>Findings include:</p> <p>During the initial tour on 8/10/16 at 12:20 p.m., the survey results were not observed.</p> <p>On 8/10/16 at 3:20 p.m., the survey book was provided. The book was kept behind the secretary's desk. The book was not visible behind a plant. The last survey in</p>	R 0042	<ol style="list-style-type: none"> The StateSurvey book was updated with surveys since the last annual re-licensure survey. Currentresidents have the potential to be affected by the alleged deficientpractice. TheAdministrator-In-Training was trained on the requirement for survey results on8/19/16 by Care Services Specialist. TheSurvey book was placed in a wall pocket with easy access and visibility to thepublic and residents on 8/19/16. The ExecutiveDirector is responsible for sustained compliance. The Executive Director and/or designee willupdate the binder after each survey, and will 	09/01/2016

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 08/11/2016	
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 0241 Bldg. 00	<p>the book was dated 9/23/15.</p> <p>During an interview with the Administrator in Training (AIT) on 8/10/16 at 3:20 p.m., she indicated only annual surveys were kept in the book, but complaints were not.</p> <p>On 8/10/16 at 1:35 p.m., CNA #3 indicated the book used to be placed on the table as you walk in, but it has not been there for some time.</p> <p>During an interview on 8/11/16 at 3:00 p.m., RN #1 indicated they found the old complaints in a file, not in the survey book.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure physician orders for advance directives were followed for 1 of 8 closed charts reviewed (Resident J). The facility also</p>			R 0241	<p>monitor its location during routine rounds of the community. Monitoring will be ongoing.</p> <p>1. Resident Z is deceased. Resident E was seen by her Nurse Practitioner on 7/27/2017, with documented improvement of skin irritation and an order to continue current treatment.</p>		09/10/2016

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 08/11/2016
--	---	---	---

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>failed to ensure an order for an appointment was scheduled for 1 of 9 charts reviewed for physician orders (Resident E).</p> <p>Findings include:</p> <p>1. The closed clinical record for Resident J was reviewed on 8/11/16 at 9:20 a.m. Diagnoses included, but were not limited to, cardiomyopathy, congestive heart failure, diabetes mellitus, hypertension and anxiety.</p> <p>During record review, on 6/4/16 at 9:50 p.m., Resident J was found unresponsive, no pulse or respirations. The writer indicated she checked the code status and found she did not have a Do Not Resuscitate (DNR) order on file. The note indicated chest compressions were initiated. The Emergency Management Services (EMS) responded to the call and arrived to continue chest compressions. Resident J expired at 9:17 p.m.</p> <p>During chart review, the closed chart had a red sticker on the outside of the chart, indicating "do not resuscitate."</p> <p>Review of Resident J's face sheet, no code status was noted.</p> <p>Review of the most recent Service Plan</p>		<p>2. Current residents have the potential to be affected by the alleged deficient practice.</p> <p>3. The CSM was re-trained on the appropriate process regarding identifying code status and follow up on orders on 8/15/16 by Care Services Specialist. The licensed staff was also re-trained on identifying code status and follow up on orders on 8/24/16 by CSM and Care Services Specialist.</p> <p>4. The CSM is responsible for sustained compliance. The Executive Director and/or designee will review charts for new move-ins upon move in, for code status information, including a signed DNR Order, if applicable, Advance Directives, and the Signed Out Of Hospital form, if applicable. Monitoring will be ongoing.</p> <p>The ED and/or designee will review new physician orders for follow through, weekly at a minimum.</p> <p>The ED will review findings in the monthly QI meetings, and the QI committee will determine if continued monitoring by the Executive Director is necessary based on three consecutive months of full compliance. The CSM is responsible for ongoing monitoring.</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 08/11/2016
--	---	---	---

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>Summary, dated 5/9/16, the code status indicated "CPR."</p> <p>Review of the last signed physician order's dated 4/28/16, a "NO CODE" was at the top of the order sheet. The order was dated 8/12/15.</p> <p>During an interview on 8/11/16 at 9:49 a.m., LPN #2 indicated she thought Resident J was a DNR, but had a feeling to check the chart for a DNR order. She indicated she looked through the chart and could not find one, then quickly called hospice. She indicated the hospice company did not have a DNR on file either. She indicated she called the previous Director of Nursing (DON) and she stated to "run full code." She indicated after this, herself and another nurse, who no longer worked at the facility, found 7 or 8 red stickers on the outside of charts with no DNR on file.</p> <p>During an interview on 8/11/16 at 1:26 p.m., RN #1 indicated she went through the current charts to make sure the orders matched the stickers, orders were correct and DNR forms were in the charts. She corrected 12 charts, as well as, placed a red or green sticker outside each resident room indicating a code status.</p> <p>2. The clinical record for Resident E was</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 08/11/2016
--	---	---	---

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>reviewed on 8/11/16 at 7:55 a.m. Diagnoses included, but were not limited to, hypertension, dementia, hyperlipidemia and pacemaker.</p> <p>Review of a current Service Plan Summary, dated 6/24/16, the "SPECIAL SERVICES" indicated Resident E required assistance in coordinating care with her physician.</p> <p>Review of Resident Services Notes, dated 7/13/16 at 9:00 a.m., indicated a red, raised rash was noted to the bilateral lower extremities (BLE). The Nurse Practitioner (NP) assessed the resident and gave a new order to change her soap and lotion.</p> <p>On 7/20/16 at 9:00 a.m., the NP gave an order for a dermatology appointment. The order was taken by a nurse who no longer worked at the facility.</p> <p>A physician's order, dated 7/20/16, indicated a dermatology consult was ordered related to "rash resistant to tx [treatment]."</p> <p>On 7/21/16 at 6:30 p.m., the note indicated the rash continued to itch. The NP was called and a new order for Elimite (anti-parasite medication used to treat scabies) was received. Resident E</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 08/11/2016
--	---	---	---

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>was treated on 7/23/16 with Elimate.</p> <p>On 7/25/16 at 1:00 p.m., the note indicated the rash continued on the BLE. Resident E complained of itching and the physician was aware.</p> <p>On 7/26/16 at 10:00 a.m., the note indicated the rash continued on the BLE.</p> <p>No additional documentation was noted related to a rash after 7/26/16.</p> <p>During an interview on 8/11/16 at 3:50 p.m., RN #1 indicated she could not find that a dermatology appointment was made.</p> <p>Review of a current facility policy, dated 7/1/14, provided by the RN #1 on 8/11/16 at 4:32 p.m., titled "PHYSICIAN ORDERS" indicated the following:</p> <p>"I. The Community must have proper physician's orders before providing assistance with any medication or treatment. Orders may be received from a physician in any of the formats outlined below:</p> <p>...III. Orders for medications and treatments must be transcribed to the MAR.</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 08/11/2016
--	---	---	---

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 0406 Bldg. 00	<p>IV. Orders for services, whether provided by community staff or outside providers, must also be initiated. This State tag relates to Complaint IN00206126.</p> <p>410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.</p> <p>Based on observation, interview and record review, the facility failed to establish an infection control program. This deficiency had to potential to affect 33 of 33 residents who resided in the facility.</p> <p>Findings include:</p> <p>During review of the Medication Administration Book for 2 of 2 halls on 8/10/16 at 12:30 p.m., a total of 31 residents were treated with Elimate (anti-parasite medication used to treat scabies) from 7/21/16 through 7/23/16. During an interview on 8/10/16 at 1:00 p.m., LPN #2 indicated she went to a walk-in clinic around 7/20/16. She indicated she did not have a skin scraping for scabies, but was treated for scabies.</p>	R 0406	<ol style="list-style-type: none"> 1. The company's infection control program and policy was reviewed and accepted on 5/23/2016 by the Vice President of Quality and Clinical Services, and the company Medical Director. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. The CSM was re-trained on 8/15/16 by Care Services Specialist on the policy regarding infection control, and the Infection control tracking tool. 4. The CSM will be responsible for sustained compliance. The ED and/or designee will review the infection control log monthly at a minimum, in monthly QI meetings, to ensure completion and 	09/10/2016

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 08/11/2016
--	---	---	---

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>She indicated all the staff and residents were treated for scabies.</p> <p>During an interview on 8/11/16 at 1:30 p.m., RN #1 indicated a home hospice aide who provided care in the facility had a positive skin scraping for scabies. She indicated the residents in the facility were treated prophylactically as a precaution.</p> <p>During an observation on 8/11/16 at 8:45 a.m. with LPN #2, Resident F was asked to transfer to the bathroom so LPN #2 could apply her topical cream. Resident F had a rash between her abdominal folds and groin area. LPN #2 applied Critic-Aid (moisture barrier) to the area. Resident F was treated with Elimite on 7/23/16.</p> <p>During an observation and interview on 8/11/16 at 2:30 p.m., Resident D indicated she had a current rash that itched all the time. Resident D indicated she had no previous problems with skin issues. She indicated she had been treated twice for scabies. Resident D had 2 small, fluid-filled pustules on her right forearm. She indicated she had them all over her back as well. Resident D was treated with Elimite on 7/23/16 and again on 7/30/16.</p> <p>During an observation and interview on 8/11/16 at 2:45 p.m., Resident C indicated she had a rash for about 3 weeks. She indicated she had no past history of any skin problems. She indicated she was</p>		<p>identified trends. 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 08/11/2016
--	---	---	---

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>currently taking a medication which was helping. Resident C raised her sleeves and she had small, pinprick scabs on both forearms. Resident C was treated with Elimite on 7/23/16.</p> <p>During an observation on 8/11/16 at 4:10 p.m., RN #1 and LPN #2 went to assess the current skin condition of Resident E. A nickel size blister was noted on the top right foot. The blister was red in color and had no drainage. A rash was noted on both the right and left arm of Resident E. Resident E stated to RN #1 that her back was also itching. RN #1 applied lotion to her back and stated it appeared as dry skin. Resident E was treated on 7/23/16 with Elimite cream.</p> <p>Review of an Indiana State Department of Health (ISDH) reportable on 8/10/16 at 3:20 p.m., indicated on 7/21/16, a total of 8 residents and 10 staff were treated for scabies.</p> <p>On 8/11/16 at 4:55 p.m., RN #1 indicated she could not find any infection control book or tracking information. She indicated the previous Director of Nursing and Administrator were no longer with the company and she was unable to find any information. She indicated there was not an actual infection control program and/or policy, but the facility followed the ISDH guidelines.</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 08/11/2016
--	---	---	---

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>Review of a current facility policy, dated 7/1/14, and titled "PREVENTING TRANSMISSION OF INFECTION", provided by the Executive Director on 8/11/16 at 5:15 p.m., indicated the following:</p> <p>"I. According to the CDC, handwashing is the most important...</p> <p>II. Standard precautions are a set of precautions developed by the Centers for Disease Control...such as gloves, gowns,...potentially infective materials.</p> <p>III. Employees with transmissible infectious diseases or infected skin lesions shall not have direct contact with residents or their food.</p> <p>...V. Education about infection control...recognize signs and symptoms that may indicate an infection...."</p> <p>No further information was provided before exit on 8/11/16.</p> <p>This State tag relates to Complaint IN00206126.</p>			