

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 03/06/2012
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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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R0000	<p>This visit was for a State Residential Licensure Survey</p> <p>Survey dates: 3/5/12 and 3/6/12</p> <p>Facility number: 003376 Provider number: 003376 AIM number: N/A</p> <p>Survey team: Linn Mackey, RN-TC Shelly Reed, RN</p> <p>Census bed type: Residential: 39 Total: 39</p> <p>Census payor type: Other: 39 Total: 39</p> <p>Residential sample: 5</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 9, 2012 by Bev Faulkner, RN</p>	R0000	<p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists, or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who draft or may be discussed in the Response and 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.</p>	
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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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R0036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (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, record review and interview, the facility failed to notify the physician of refusal of TED (Thrombo-Embollic Deterrent) hose for 1 of 1 resident reviewed in a sample of 5. (Resident # 1)</p> <p>Findings include:</p> <p>During record review on 3/5/12 at 11:00 a.m., Resident # 1 diagnoses included but are not limited to Lewy Body Dementia, hypothyroidism, hypertension, anxiety and depression.</p> <p>Resident # 1 had an physician order written 1/4/12 for "... TED hose on am off pm...."</p> <p>Review of the Medication Administration Record for 2/2012 indicated the TED hose were applied to the resident for 16 of the 29 days of February. The facility</p>	R0036	Resident #19's physician was notified 3-6-12 that the resident has been refusing to wear Thrombo-Embollic Deterrent (TED) hose as per physician orders. Reviewed current residents' Medication Administration Records (MARs) for refused medications or treatments as per physician orders. No deficiencies were found an no other residents were found to be directly affected by the practice. Wellness Director will review medication administration records weekly when administering medications, for resident refusals and ordering physician notification. Regional Director of Quality and Care Management (RDQCM) will monitor MAR for resident refusals monthly for four (4) months and then quarterly thereafter to ensure compliance.	04/06/2012			

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	<p>nurses notes did not indicate that the doctor had been notified of the refusal of the TED hose.</p> <p>During an observation on 3/5/12 at 10:00 a.m., Resident # 1 was sitting in a wheelchair in the dining room and did not have his TED hose on. The resident was noted to have edema to the lower extremities. During an observation on 3/5/12 at 12:20 p.m., the resident was in a recliner in his room and was not wearing TED hose.</p> <p>During an observation on 3/6/12 at 9:05 a.m., Resident # 1 did not have his TED hose on. When CNA#5 was queried, the CNA indicated that resident frequently refused his TED hose. CNA #5 indicated resident would kick employees to indicate he did not want the TED hose on.</p> <p>During an observation 3/6/12, the hospice nurse indicated she wanted his TED hose applied. CNA # 5 could not find the resident's TED hose in his room.</p> <p>A document titled TASK LIST was provided by the Wellness Director on 3/6/12, at 9:20 a.m. The list indicated "... IF RESIDENT REFUSES CARE IT MUST BE DOCUMENTED AND REPORTED TO WD (Wellness Director OR RD (Residence Director)..."</p>			

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	<p>A document titled Medication Refusal was provided by the Residence Director on 3/6/12 at 1:15 p.m. The document indicated when a medication or treatment is refused for any reason. Notify the Wellness Director the first time a resident refuses. The nurse should then notify the resident's physician.</p>			

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R0090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be</p>						

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	<p>available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on observation and interview, the facility failed to prominently display the results of the most recent annual survey and failed to make the results easily accessible to residents. This practice potentially affected 39 of 39 residents who reside in the facility.</p> <p>Finding Include:</p> <p>During the environmental walk through tour with the Wellness Director on 3/5/12 at 9:20 a.m., the Wellness Director was asked to provide the most recent survey results of the facility. She proceeded to go behind the nurse's station and retrieve the survey book from an upper cabinet.</p> <p>During an interview with the Wellness Director on 3/5/12 at 9:25 a.m., she indicated the survey book was kept in the upper cabinet.</p>	R0090	<p>No specific resident concern No other residents were identified as having the potential to be directly affected by the practice. Notice of location of recent Indiana state survey results posted in view of residents and others. Recent survey binder readily available upon request. Staff in-serviced on location of survey binder. Regional Director of Quality and Care Management (RDQCM) will monitor notice of binder posting and binder location monthly for four (4) months and then quarterly thereafter to ensure compliance</p>	04/06/2012

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R0117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on interview and record review, the facility failed to ensure cardiopulmonary resuscitation (CPR) and first aid certificate were completed for 4 of 16 employees. (E#6, E#7, E#8, E#9). This had the potential to affect 39 of 39 residents.</p> <p>Findings include:</p>	R0117	No specific resident concern No other residents were identified as having the potential to be directly affected by the practice. Employees #6,#7,#8,#9 completed CPR and first aid certification on 3-6-12. Residence Director reviewed current employee files to confirm files are up to date with appropriate training verification. Residence Director in-serviced on CPR and first aide requirements for staff. The Regional Director of	04/06/2012			

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	<p>During a record review on 3/5/12 at 2:20 p.m., the schedule for the month of February 2012 and the license, CPR and First Aid certifications were reviewed. The following dates were without staff with CPR and first aid certification, 2/16/12 through 2/19/12, 2/22/12 and 2/23/12, and 2/27/12 and 2/29/12. The affected time was the night shift with hours of 10:00 p.m. until 6:00 a.m.</p> <p>During a review of CPR and first aide certification records, 4 of 16 employees did not have current certification. (E#6, E#7, E#8, E#9)</p> <p>During an interview on 3/5/12 at 3:00 p.m., the Wellness Director was informed of the lack of certifications and provided no additional information at that time.</p> <p>During an interview with the Residence Director 3/6/12 at 11:30 a.m.. The Residence Director indicated that she replaced staff on 3/5/12 with staff that was certified in CPR. She also indicated the affected staff members were currently being trained for CPR.</p>		Operations will review employee records for current CPR and first aid certification for four months then quarterly thereafter to ensure staffing compliance				

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R0120	<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> <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 6 hours of</p>	R0120	No specific residents affected No other residents were identified as having the potential to be directly	04/06/2012			

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	<p>dementia-specific training for new employees and 3 hours of dementia-specific training annually for existing employees for 3 of 24 employees reviewed (Employee #'s 3, 10, and 13).</p> <p>Findings include:</p> <p>Employee #3's file was reviewed on 3/6/12 at 1:30 p.m. Her hire date was indicated to have been on 3/11/11 and she had completed 3 hours and 45 minutes of dementia-specific training to date.</p> <p>Employee #10's file was reviewed on 3/6/12 at 1:35 p.m. Her hire date was indicated to have been on 2/8/11 and she had completed 90 minutes of dementia-specific training to date.</p> <p>Employee #13's file was reviewed on 3/6/12 at 1:46 p.m. Her hire date was indicated to have been on 9/9/11 and she had completed 45 minutes of dementia-specific training to date.</p> <p>During and interview with the Resident Director on 3/6/12 at 2:10 p.m., she indicated that the employees received individual resident training but she did not provide any additional documented dementia training for Employees #'s 3, 10, and 13</p>		<p>affected by the practice. Employee #3 completed a total of 6 hours of dementia training on 3-27-08. Employee #10 completed a total of 6 hours of dementia training on 9-8-04. Employee #13 completed a total of 6 hours of dementia training on 3-23-12. Residence Director will schedule and have documentation of participation of dementia training, six hours within first six months of employment for newly hired employees who have not yet acquired six hours of dementia training and three hours annually thereafter for all employees Regional Director of Operations will audit new employee files randomly for four months then quarterly thereafter to ensure compliance</p>				

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R0144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the facility environment was in a state of good repair related to painted walls, doors and baseboards for 3 of 3 hallways and 1 of 1 main living area potentially affecting 39 of 39 residents residing in the facility.</p> <p>Finding include:</p> <p>During the environmental walk through tour with the Maintenance Director on 3/6/12 at 8:10 a.m., the paint in 3 of 3 hallways and in the common living area was chipped, scratched and discolored on the baseboards, walls and doors.</p> <p>During an interview with the Maintenance Director on 3/6/12 at 8:20 a.m., he indicated the facility was in need of paint throughout the halls and main living area.</p>	R0144	<p>No residents were directly affected. No other residents were identified as having the potential to be directly affected by the practice.</p> <p>Hallways and common area were touched up with paint on 3-30-12. Maintenance Director was in-serviced on policy and procedures related to completing work orders and preventative maintenance. Staff were in-serviced on identifying and reporting work orders.</p> <p>Residence Director, Regional Maintenance Technician and/or Regional Director of Operations will audit facility monthly to ensure it is clean, orderly, and in good repair for four months, then quarterly thereafter to ensure compliance.</p>	04/06/2012			

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R0148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interview, the facility failed to ensure handrails were maintained free of hazards potentially affecting 39 of 39 residents who reside in the facility.</p> <p>Findings include:</p> <p>During the environmental walk through tour with the Maintenance Director on 3/6/12 at 8:10 a.m., the North hall had a handrail across from Room 119 that was sharp and splintered. The South hall handrail across from the main living room had 2 nails that were exposed and sharp.</p> <p>During an interview with the Maintenance Director on 3/6/12 at 8:20 a.m., he</p>	R0148	<p>No specific residents affectedNo other residents were identified as having the potential to be directly affected by the practice.The north hall side rail was sanded on 3-6-12 and is no longer sharp and splintered. The south hall exposed nail was removed and area sanded on 3-6-12. Maintenance Director was in-serviced on policy and procedures related to completing work orders and preventative maintenance. Staff were in-serviced on identifying and reporting work orders.Residence Director, Regional Maintenance Technician and/or Regional Director of Operations will audit facility that it is clean, orderly, and in good repair during House Tour for four months then quarterly</p>	04/06/2012			

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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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	indicated the North hall handrail would need to be sanded and re-stained and the South hall handrails would need to be repaired to fix the exposed nails.		thereafter to ensure compliance	

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R0214	<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, observation, and interview, the facility failed to ensure an evaluation/assessment of a resident's heel ulcer was completed when discovered and ongoing evaluations of the pressure area were completed for 1 of 1 resident in a sample of 5. (Resident #1)</p> <p>Findings include:</p> <p>During record review on 3/5/12 at 11:00 a.m., Resident # 1 current diagnoses include, but are not limited to Lewy Body Dementia, hypothyroidism, hypertension, anxiety and depression.</p> <p>Resident # 1 had a current physician's order, dated 2/22/12, for Duoderm to Right back of heel open area. Change every 3 to 5 days and as needed until healed.</p> <p>A hospice nurse note, dated 2/22/2012, indicated a stage 2 pressure ulcer to the back of the right heel. The pressure area measured 2.3 centimeter by 1.4</p>	R0214	<p>Documentation of pressure ulcer in resident service notes for resident #1 was completed on 3-7-12 by Wellness Director. Hospice nurse documented wound assessment which included measurement on 3-6-12. Wellness Director reviewed current resident records for wound assessments and action plans. No deficiencies were found and no other residents were identified as having the potential to be directly affected by the practice. Wellness Director to document wound assessments weekly in the Resident Service Notes. Wellness Director in-serviced on policy and procedure documenting skin related issues. Regional Director of Quality and Care Management (RDQCM) will monitor service note documentation for wound assessments monthly for four (4) months and then quarterly thereafter to ensure compliance</p>	04/06/2012			

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	<p>centimeter by .2 centimeter. Review of the facility's nurses noted did not indicate a pressure area.</p> <p>During an observation of wound care on 3/6/12 at 11:30 p.m., the hospice nurse indicated the wound measured 1 centimeter by 1.2 centimeter and was almost healed and she has not measured the wound since 2/22/12.</p> <p>During an interview on 3/6/12 at 11:30 p.m., the hospice nurse indicated she did not find a the pressure area but had been informed of the pressure area by the Wellness Director.</p> <p>During an interview on 3/6/12 at 2:45 p.m., with the Residence Director she indicated they had known about the pressure area on 2/21/12. When queried, she indicated there should have been documentation in the nurse's notes related to the pressure area.</p> <p>Review of an undated document, titled "Wound Assessment," which was provided by Residence Director on 3/6/12 at 1:15 p.m., indicated the Wellness Director must complete a thorough assessment of the resident's wound and document the wound in the resident service notes weekly.</p>			

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