STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/17/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: September 16 and 17, 2025 Facility number: 003376 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 23, 2025.	R 0000		
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be	R 0217	**1** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	10/15/2025

	appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were reviewed with the resident and/or their representative and acknowledged by signature for 1		Resident 29 no longer resides at our community. **2** **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:** Audit of all resident service plans to be completed by 10/13/25. **3** **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	

	of 7 residents reviewed for service plans. (Resident 29). Finding includes: Resident 29's clinical record was reviewed on 9/17/25 at 11:00 a.m. Diagnoses included hypertension, diabetes, chronic pain, and hypothyroidism. A current service plan, dated 3/6/25, lacked the resident's or their representative's signature. During an interview, on 9/17/25 at 12:51 p.m., the Administrator indicated she was unable to find a signed service plan for Resident 29. The 3/6/25 service plan contained only a facility staff member's signature. During an interview, on 9/17/25 at 1:03 p.m., the Administrator indicated the facility did not have a policy regarding service plans, and the facility followed the state rules and regulations regarding service plans. Based on record review and interview, the facility failed to ensure service plans were reviewed with the resident and/or their representative and acknowledged by signature for 1 of 7 residents reviewed for service plans. (Resident 29). Finding includes: Resident 29's clinical record was reviewed on 9/17/25 at		Executive Director to be trained by the Regional Director of Resident Care, no later than 10/10/25, on the need to ensure all resident service plans are reviewed with/have proper signatures from the required parties. **4** **How the** **corrective action(s) will be monitored to ensure the deficient practice will** **not recure, i.e., what quality assurance program will be put into place:** Effective 10/13/25, the ED or designee will audit resident service plans for compliance with signatures of review. The audits will be performed weekly x 4 weeks, biweekly x 4 weeks, then monthly. After 3 months of consecutive compliance, the audits will be performed quarterly indefinitely to the end. Monitoring will be on-going.	

	11:00 a.m. Diagnoses included hypertension, diabetes, chronic pain, and hypothyroidism. A current service plan, dated 3/6/25, lacked the resident's or their representative's signature. During an interview, on 9/17/25 at 12:51 p.m., the Administrator indicated she was unable to find a signed service plan for Resident 29. The 3/6/25 service plan contained only a facility staff member's signature. During an interview, on 9/17/25 at 1:03 p.m., the Administrator indicated the facility did not have a policy regarding service plans, and the facility followed the state rules and regulations regarding service plans.		**5** **By what** **date the systemic changes will be completed:** 10/15/25	
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. A. Based on observation and interview, the facility failed to label, date, and store dining utensils under safe sanitary conditions. This deficiency had the potential to impact 23 of 23 residents who received meals	R 0273	**1** **What** **corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Plates and bowls are now being stored upside down and/or covered when not in use.	10/15/2025

	from the facility kitchen. B. Based on observation and interview, the facility failed to ensure food was served under safe sanitary conditions regarding food handling during meal service. This deficient practice had the potential to affect 23 of 23 residents who received their meals from the facility kitchen. Findings include: A. During a continuous kitchen observation beginning on 9/16/25 at 9:54 a.m., accompanied by Dietary Employee (DE) 4, the following was observed: Upright plates and bowls were stored uncovered on the countertop. During an interview, DE 4 indicated he did not see a problem with storing tableware upright. He was usually the only employee in the kitchen. He would be able to see any particles on the tableware, and he covered the tableware nightly. B. During a lunch observation, on 9/16/25 at 11:20 a.m., the following food handling and food service concerns were observed:		Dietary employee was verbally retrained on proper glove use, not touching hands/apron to food portions of plates/bowls, etc. (Touched gloved hand to apron, refrigerator, etc without changing gloves before going back to food handling.) (Gloved thumb pad/fingers touched food portions of plate/bowl.) (Food portion of plate touched apron.) **2 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:** Executive Director, or designee, will complete observations of meal service to monitor for deficient practices.	

	DE 4 was seen plating food while wearing gloves. DE 4 wiped his gloved hands on his apron before proceeding to the refrigerator doors. He opened the refrigerator with his gloved hands and pulled out a egg salad sandwich. He placed the plate on the prep counter. He then walked over to the steam table, picked up a soup bowl while putting his left pointer finger inside the soup bowl. He filled the soup bowl with cheesy broccoli soup before placing the bowl on the egg salad sandwich plate. The plate was then taken and served to a resident. DE 4, wearing the same gloves, picked up a plate where his left thumb pad touched the food portion of the plate. The plate was served to a resident. DE 4 then picked up another plate, pressed the plate against his apron, where the food portion of the plate touched his apron as he was scooping vegetables out of a pan before placing the vegetables onto the plate. The plate was served to a resident. During an interview, on 9/16/25 at 11:43 a.m., DE 4 indicated he did not recall touching the food portion of the plates or the inside of the soup bowl with his pointer finger. He would consider the plates and bowl still		**3** **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Dietary team will be retrained by 10/13/25 regarding proper glove usage and infection control during meal service. **4** **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:** Effective 10/13/25, the ED or designee will observe meal service to monitor for deficient practices regarding glove use and infection control. The observations will be conducted weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure proper implementation of infection use during meal	

	servable. He did not change his gloves throughout the meal service. On 9/17/25 at 9:26 a.m., the Administrator indicated DE 4 should have changed his gloves between touching dirty surfaces. A current policy, titled "Glove Use in Food Preparation Areas", provided by the Administrator, on 9/17/25 at 12:12 p.m., indicated the following: " ...3. Prohibited actions while wearing gloves. Staff wearing gloves must not: Touch aprons, uniforms, or other non-food surfaces. Wipe hands on towels, aprons, or cloths...." A current policy, titled "China Storage", provided by the Administrator, on 9/17/25 at 12:12 p.m., indicated the following: " ...5. Protection from Contamination: All stored china must be covered, inverted (face down), or otherwise protected from dust, splashes, and airborne contaminants...." A. Based on observation and interview, the facility failed to label, date, and store dining utensils under safe sanitary conditions. This deficiency had the potential to impact 23 of 23 residents who received meals from the facility kitchen. B. Based on observation and interview, the facility failed to ensure food was served under		service, including proper glove usage. After 3 months of consecutive compliance, the observations will be performed quarterly indefinitely to the end. Monitoring will be on-going. **5** **By what** **date the systemic changes will be completed:** 10/15/25	

	safe sanitary conditions regarding food handling during meal service. This deficient practice had the potential to affect 23 of 23 residents who received their meals from the facility kitchen. Findings include: A. During a continuous kitchen observation beginning on 9/16/25 at 9:54 a.m., accompanied by Dietary Employee (DE) 4, the following was observed: Upright plates and bowls were stored uncovered on the countertop. During an interview, DE 4 indicated he did not see a problem with storing tableware upright. He was usually the only employee in the kitchen. He would be able to see any particles on the tableware, and he covered the tableware nightly. B. During a lunch observation, on 9/16/25 at 11:20 a.m., the following food handling and food service concerns were observed: DE 4 was seen plating food while wearing gloves. DE 4 wiped his gloved hands on his apron before proceeding to the refrigerator doors. He opened the refrigerator with his			

	gloved hands and pulled out a egg salad sandwich. He placed the plate on the prep counter. He then walked over to the steam table, picked up a soup bowl while putting his left pointer finger inside the soup bowl. He filled the soup bowl with cheesy broccoli soup before placing the bowl on the egg salad sandwich plate. The plate was then taken and served to a resident. DE 4, wearing the same gloves, picked up a plate where his left thumb pad touched the food portion of the plate. The plate was served to a resident. DE 4 then picked up another plate, pressed the plate against his apron, where the food portion of the plate touched his apron as he was scooping vegetables out of a pan before placing the vegetables onto the plate. The plate was served to a resident. During an interview, on 9/16/25 at 11:43 a.m., DE 4 indicated he did not recall touching the food portion of the plates or the inside of the soup bowl with his pointer finger. He would consider the plates and bowl still servable. He did not change his gloves throughout the meal service. On 9/17/25 at 9:26 a.m., the Administrator indicated DE 4 should have changed his gloves			

	between touching dirty surfaces. A current policy, titled "Glove Use in Food Preparation Areas", provided by the Administrator, on 9/17/25 at 12:12 p.m., indicated the following: " ...3. Prohibited actions while wearing gloves. Staff wearing gloves must not: Touch aprons, uniforms, or other non-food surfaces. Wipe hands on towels, aprons, or cloths...." A current policy, titled "China Storage", provided by the Administrator, on 9/17/25 at 12:12 p.m., indicated the following: " ...5. Protection from Contamination: All stored china must be covered, inverted (face down), or otherwise protected from dust, splashes, and airborne contaminants...."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as	R 0298	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Current temperature was taken to ensure it was withing proper range for medication storage. **1**	10/15/2025

	medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview, and record review, the facility failed to ensure biologicals requiring refrigeration were monitored per medication guidelines for 1 of 1 refrigerators reviewed for medication/biological storage. Findings include: During an observation of the medication storage room, on 9/17/25 at 9:06 a.m., with QMA 3 present, the medication refrigerator contained five eye drop vials, four unopened Lantus insulin pens, 17 unopened Humalog insulin pens, and two vials of tuberculin testing serum. The refrigerator log indicated the refrigerator temperature was not being monitored daily. For the month of August 2025, only one day was completed. During an interview, on 9/17/25 at 9:12 a.m., QMA 3 indicated the maintenance staff checked the refrigerator temperatures		**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:** Executive Director placed current temperature log on refrigerator used for medication storage. **2 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Medication Techs will be trained to ensure temperature is recorded daily. All training will be completed no later than 10/13/25. **3 How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality**	

	and completed the log. On 9/17/25 at 9:26 a.m., the Administrator indicated maintenance and housekeeping were responsible for checking the refrigerator temperatures and completing the log. Refrigerator temperatures were not being completed. A current policy, titled "Medication Storage", provided by the Administrator, on 9/17/25 at 10:35 a.m., indicated the following: " ...4b. The refrigerator temperature is checked daily and documented on the Daily Refrigerator Temperature Control Log...." Based on observation, interview, and record review, the facility failed to ensure biologicals requiring refrigeration were monitored per medication guidelines for 1 of 1 refrigerators reviewed for medication/biological storage. Findings include: During an observation of the medication storage room, on 9/17/25 at 9:06 a.m., with QMA 3 present, the medication refrigerator contained five eye drop vials, four unopened Lantus insulin pens, 17 unopened Humalog insulin pens, and two vials of tuberculin testing serum. The refrigerator log indicated the refrigerator temperature was not being		**assurance program will be put into place:** Effective 10/13/25, the ED or designee will audit the medication storage temperature log weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure that medications are not being improperly stored. After 3 months of consecutive compliance, the observations will be performed quarterly indefinitely to the end. Monitoring will be on-going. **4** **By what date the systemic changes will be completed:** 10/15/25	

	monitored daily. For the month of August 2025, only one day was completed. During an interview, on 9/17/25 at 9:12 a.m., QMA 3 indicated the maintenance staff checked the refrigerator temperatures and completed the log. On 9/17/25 at 9:26 a.m., the Administrator indicated maintenance and housekeeping were responsible for checking the refrigerator temperatures and completing the log. Refrigerator temperatures were not being completed. A current policy, titled "Medication Storage", provided by the Administrator, on 9/17/25 at 10:35 a.m., indicated the following: " ...4b. The refrigerator temperature is checked daily and documented on the Daily Refrigerator Temperature Control Log...."			
R 0328	Activities Programs - Noncompliance 410 IAC 16.2-5-7.1(c)(1-3) (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant.	R 0328	**1** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An Activity Director was hired on 9/29/25.	09/29/2025

	(3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division. Based on interview and record review, the facility failed to employ an Activities Director. Findings include: During an interview, on 9/16/25 at 12:20 p.m., the Administrator indicated the facility currently did not have an Activity Director. A staff member from a sister facility approved the resident activities. She was available by phone or email, but had not been physically in the building since December 2024. During an interview, on 9/16/25 at 2:06 p.m., the Administrator indicated the Activity Director position had been vacant since the last annual survey was conducted in November 2024. During an interview, on 9/17/25 at 11:15 a.m., the Administrator indicated the facility did not have a policy regarding the Activity Director. The facility followed State Regulations. A current facility job description, titled "Celebration Coordinator" provided by the Administrator on 9/17/25 at 12:12 p.m., indicated the following: "... Assists in planning, scheduling and conducting programs that		**2** **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:** An Activity Director was hired on and began training on 9/29/25. **3** **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The facility will have an activity director on staff, and/or a qualified individual overseeing the activity program. **4** **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be**	

	provide physical, intellectual, social, emotional and spiritual opportunities for the resident's ...." Based on interview and record review, the facility failed to employ an Activities Director. Findings include: During an interview, on 9/16/25 at 12:20 p.m., the Administrator indicated the facility currently did not have an Activity Director. A staff member from a sister facility approved the resident activities. She was available by phone or email, but had not been physically in the building since December 2024. During an interview, on 9/16/25 at 2:06 p.m., the Administrator indicated the Activity Director position had been vacant since the last annual survey was conducted in November 2024. During an interview, on 9/17/25 at 11:15 a.m., the Administrator indicated the facility did not have a policy regarding the Activity Director. The facility followed State Regulations. A current facility job description, titled "Celebration Coordinator" provided by the Administrator on 9/17/25 at 12:12 p.m., indicated the following: "... Assists in planning, scheduling and conducting programs that provide physical, intellectual,		**put into place:** n/a **5** **By what** **date the systemic changes will be completed:** 9/29/25	

	social, emotional and spiritual opportunities for the resident's ...."			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a tuberculin (TB) skin test was completed with documented times on or prior to admission for 2 of 7 residents	R 0410	**1** **What** **corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 29 no longer resides at our community. Resident 6 will have her skin test repeated, properly, to ensure negative result. **2** **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:** All current mantoux records will be audited by Executive Director, or designee, to ensure all current resident skin tests are within compliance/have time documented. Audit will be	10/15/2025

reviewed for TB administration. (Resident 6 and Resident 29)

Findings include:

Resident 6's clinical record was reviewed on 9/16/25 at 2:00 p.m. The record lacked documentation of the times the resident's first and second step TB skin test had been read.

Resident 29's clinical record was reviewed on 9/17/25 at 11:00 a.m. Resident 29 was admitted to the facility on 3/20/25. A first step TB was administered on 4/7/25. A second step was administered on 4/16/25 and lacked documentation of the administration time. The second step TB test was read on 4/18/25 and lacked documentation of the time it was read.

During an interview, on 9/17/25 at 12:51 p.m., the Administrator indicated Resident 6 and Resident 29's TB record lacked documented times.

A current facility policy, dated 6/10/24, titled, "IC-14 Tuberculosis: Resident," provided by the Administrator on 9/17/25 at 1:03 p.m., indicated the following:.."Policy: The Community will screen all residents for TB infection and disease upon admission or readmission. Additionally, residents will be screened

completed by 10/13/25. Any current skin without proper documentation will be brought into compliance.

3
What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

Nursing staff that hold current certification to administer TB skin test will be trained on ensuring to include time stamp at time of administration and reading.

4
How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:

Effective 10/13/25, the ED or designee will audit

	annually per Indiana regulations. Procedure: 1. The Community will screen residents at the time of admission and readmission for information regarding exposure to or symptoms of TB. a. A skin TB test must be completed within three (3) months prior to admission or upon admission and read within forty-eight (48) to seventy-two (72) hours ...." Based on record review and interview, the facility failed to ensure a tuberculin (TB) skin test was completed with documented times on or prior to admission for 2 of 7 residents reviewed for TB administration. (Resident 6 and Resident 29) Findings include: Resident 6's clinical record was reviewed on 9/16/25 at 2:00 p.m. The record lacked documentation of the times the resident's first and second step TB skin test had been read. Resident 29's clinical record was reviewed on 9/17/25 at 11:00 a.m. Resident 29 was admitted to the facility on 3/20/25. A first step TB was administered on 4/7/25. A second step was administered on 4/16/25 and lacked documentation of the administration time. The second step TB test was read on 4/18/25 and lacked		Mantoux logs for all newly administered skin tests weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure that medications are not being improperly stored. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5** **By what date the systemic changes will be completed:** 10/15/25	

	documentation of the time it was read. During an interview, on 9/17/25 at 12:51 p.m., the Administrator indicated Resident 6 and Resident 29's TB record lacked documented times. A current facility policy, dated 6/10/24, titled, "IC-14 Tuberculosis: Resident," provided by the Administrator on 9/17/25 at 1:03 p.m., indicated the following:..."Policy: The Community will screen all residents for TB infection and disease upon admission or readmission. Additionally, residents will be screened annually per Indiana regulations. Procedure: 1. The Community will screen residents at the time of admission and readmission for information regarding exposure to or symptoms of TB. a. A skin TB test must be completed within three (3) months prior to admission or upon admission and read within forty-eight (48) to seventy-two (72) hours ...."				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURESteffani Dranchak	TITLERN	(X6) DATE10/22/2025