STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/29/2026

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 the Investigation of Intakes 469882. Intake 469882 - State deficiencies related to the allegations are cited at R064 and R306. Survey date: May 28 and 29, 2026 Facility number: 003376 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 8, 2026.	R 0000		
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss	R 0064	Immediate Action: 1. Performed a count for Resident B and verified the medication was	06/23/2026

	and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure a resident's controlled substances were accounted for in a manner that prevented loss or misappropriation per facility policy for 1 of 3 residents reviewed for misappropriation. (Resident B) Findings include: Resident B's clinical record was reviewed on 5/28/26 at 1:13 p.m. Diagnoses include spinal stenosis, lumbar region with neurogenic claudication, repeated falls, and wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing. Orders included Norco (opiate pain medication) 5-325 milligram one tab every four hours as needed (PRN). During an interview, on 5/28/26 at 2:05 p.m., QMA 17 indicated that Resident B's narcotic count was consistently incorrect for oxycodone (narcotic pain medication) and Norco (narcotic pain medication). On 5/20/26 at 4:00 p.m., there was no QMA to		missing from the cart.Immediately notified physician and requested replacement medication for Resident B 2. 30 residents had the potential to be affected by this issue.Performed a full controlled substance count in all carts.No other counts were identified as being incorrect. 3. In-service provided to all staff regarding: 1. Resident rights 2. Controlled count policy 1. Notification and timeline for report of discrepancy in count 3. Process for exchange of keys Inservice will be completed for all staff by 6/23/26. On-going monitoring: 1. Paper controlled substance tracking form will be used in tandem with electronic MAR blind controlled count system.DHW will review controlled counts daily for 2 weeks.If no discrepancies are noted, DHW will review 3 times a week for 2 weeks, then at least 1 time per week ongoing.ED will be	

	relieve her and a narcotic count was not completed. When there was no oncoming QMA, she normally placed the medication cart keys in a combination locked filing cabinet drawer located in the medication room or completed a narcotic count with the DON. On 5/20/26, as she placed the keys in the filing cabinet drawer, QMA 32, who did not normally work as a QMA, took the keys. When QMA 17 returned to work on 5/21/26 at 6:00 a.m., Resident B's discontinued oxycodone, remained in the narcotic box, and the Norcos were missing. Neither medication appeared in the electronic narcotic count system. She attempted to enter the Norco count into the EHR (electronic health record) but received error messages when entering three pills from the blister card of Resident B's previous as needed prescription, then totaled the two and entered 15 pills, and then 12 pills from the bottle. QMA 45 had completed the narcotic count with her on 5/20/26 and again on 5/21/26 at 6:00 a.m. She reported the missing medications to the DON on 5/21/26 and wrote the information on a Post-it note as a reminder to the DON. All staff had access to the medication room, the medication cart was normally locked, and only the QMAs had the combination to		notified immediately of any discrepancies and will investigate per policy.Audits will be reviewed during 1:1 ED/DHW meetings.	

	the filing cabinet lock. During an interview, on 5/28/26 at 4:34 p.m., with the DON and the Administrator, the DON indicated the missing Norcos were reported to her in the afternoon of 5/21/26 after attending an out of the facility event. Resident B's Norco came from an outside pharmacy, picked up by the resident's daughter, and dropped off at the facility. Resident B had been recently hospitalized for a fracture and had previously received the same PRN medication in a blister card form. The Administrator indicated she believed the medication could had been manually entered into the EHR, but the DON indicated that she had not done so and was unsure how. The DON had noticed the Norco bottle in the cart with 12 pills originally in the bottle. The Administrator indicated that on 5/20/26 the Norco was accounted for during the morning narcotic count by QMAs 17 and 45. QMA 17 left at 4:00 p.m. and passed on the keys to QMA 32 without completing a narcotic count. QMA 32 completed a narcotic count with QMA 57 at 6:00 p.m., and QMA 57 completed a narcotic count with QMA 45 at 10:00 p.m. When QMA 17 arrived at 6:00 a.m. on 5/21/26, the bottle of Norco was missing.			

	No staff were drug tested as there was no reasonable suspicion and the investigation was unsubstantiated. They hoped the Norco was mistakenly placed in the drug disposal box, but no staff admitted to doing so. During an interview, on 5/29/26 at 7:48 a.m., the DON indicated Resident B's Norco was paid for by insurance. It was replaced and reordered by the resident's nurse practitioner. During an interview, on 5/29/26 at 9:11 a.m., QMA 57 indicated on 5/20/26, she completed a narcotic count and there were eight pills in the bottle. She was unsure if it was Resident B's oxycodone or Norco. There were not two bottles in the medication cart for Resident B. During an interview, on 5/29/26 at 9:36 a.m., QMA 32 indicated that she had the medication cart keys for two hours on 5/20/26. She did not complete a narcotic count with QMA 57 at shift change. Resident B's name did not appear in the electronic count system. During an interview, on 5/29/26 at 10:00 a.m., the DON indicated that she did not know how to enter the Norco from the outside pharmacy into the EHR for the narcotic count. The QMAs were supposed to			

	document the Norco count on a narcotic count sheet in the PRN binder. Resident B had a blister card containing two Norco pills, which alerted the QMAs to count the Norcos in the bottle. Once the last two Norcos were administered, the system did not alert the QMAs to count the bottle of Norco. The QMAs should count with the oncoming shift and if there were no QMAs at shift change, she would complete the narcotic count with the QMA at 4:00 p.m. The computer system did not allow more than one narcotic count per shift, preventing an additional count when a QMA arrived at 6:00 p.m. A copy of a Post-it note was provided by the Administrator, on 5/29/26 at 10:15 a.m., that indicated Resident B had 14 pills, two pills in a blister card and 12 pills in a bottle. A handwritten note indicated the count was given to the DON on 5/20/26 at the end of QMA 17's shift. Two Norcos remained in a blister card and a bottle of 12 Norco 5-325 mg was accounted for in the medication cart. During an interview on 5/29/26 at 10:43 a.m., QMA 62 indicated she believed that if there was not a QMA to complete a narcotic count at shift change then they were supposed to count with a CNA. QMAs who			

	needed to leave early could place the keys in the combination locked filing cabinet. During an interview, on 5/29/26 at 2:36 p.m., QMA 21 indicated at times, she placed the keys in the combination-locked filing cabinet at the end of her shift and had been instructed to count with a CNA when no QMA was available at shift change. On 5/22/26, the facility reported to the Indiana Department of Health that a bottle of prescribed narcotic pain medication was missing from the medication cart. The bottle had been documented to contain 12 pills at the time of the last recorded count. The facility obtained a new prescription to maintain the resident's pain management, and staff notified law enforcement of the missing medication. A current facility policy, dated 6/10/24, titled "Personal Rights," and provided by the Administrator, on 5/29/26 at 3:09 p.m., indicated the following: "...Procedure...4. Resident Rights include the following...w. The facility shall exercise reasonable care for the protection of residents' property from loss and theft. The administrator or his or her designee is responsible for			

	investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident...." A current facility policy, dated 6/10/24, titled "Controlled Substance Management," provided by the Administrator on 5/29/26 at 3:09 p.m., indicated the following: "...Procedure: 1. Controlled Substance Storage. Precautions will be enforced to ensure that all Controlled Substances are properly accounted for and destroyed as indicated in this policy to prevent drug diversion...c. 1. If the QMA leaves the Community for any reason (lunch, break, outside appointment, etc.) the keys will be transferred to another QMA or supervisor on-duty. 2. Any time keys are passed, both staff members will count all Controlled Substances, and sign-off on the Controlled Substance Shift Count Form...b. A Controlled Substance Medication Record form is on file for every Controlled Substance brought into the Community, including refills. i. Multiple bubble packs or bottles for the same medication must have individual Controlled Substance Medication Record sheets and be numbered (1 of 3, 2 of 3, 3 of 3, etc.) 1. a. If the pharmacy did not deliver a Controlled Substance medication form with the			

	medication, staff will use the Controlled Substance Medication Record form...4. Controlled Substance Shift Counts: a. Shift counts are performed at the end of each shift, or when the QMA responsible for medications changes. i. A complete count will take place by the QMA going-off and the QMA coming on. ii. The QMA on shift pulls the Controlled Substance Shift Count form and reports to the on-coming QMA the quantity of medication that should be in each package. iii. The oncoming QMA counts the medication in container and verifies the count. b. If the quantity is verified both the on-coming and off-going QMAs will sign the Controlled Substance Shift Count Form. i. The Controlled Substance count sheets or bound book from the pharmacy may be used...c. iv. If the count cannot be verified, the discrepancy will be immediately reported to the Executive Director...." This citation relates to Intake 469882.			
R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate	R 0306	Immediate Action: 1. For resident B, full audit of physician orders was completed to verify active orders.Any discontinued	06/10/2026

	federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure a resident's controlled substances were disposed of per facility policy for 1 of 3 residents reviewed for misappropriation. (Resident B) Findings include: Resident B's clinical record was reviewed on 5/28/26 at 1:13 p.m. Diagnoses include spinal stenosis, lumbar region with neurogenic claudication, repeated falls, and wedge		medication was pulled from storage and destroyed. 2. This had the potential to affect 30 residents.Complete cart audit was completed.No other discontinued medications were in cart. 3. In-service provided to medication administration personnel: 1. Review Medication Policy : MP18 – Permanent Discontinuance of Medication(s) 2. Review Medication Policy: MP21 – Medication Disposal and Destruction Inservice will be completed by 6/23/26 4. DHW will review resident orders for discontinued meds daily.DHW will perform cart audits for discontinued medications daily for 2 weeks.If no discrepancies are noted, DHW will review 3 times a week for 2 weeks, then at least 1 time per week ongoing.ED will be notified immediately of any discrepancies and will investigate per policy.Audits will be reviewed during 1:1 ED/DHW meetings.	

compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing.

The hospital "After Visit Summary," dated 5/17/26, provided by the Administrator, on 5/29/26 at 10:15 a.m., indicated to stop taking oxycodone (opioid pain medication) 5 milligram (mg).

Resident B's Inventory History, provided by the Administrator, on 5/28/26 at 9:26 p.m., indicated on 5/20/26 at 8:54 a.m. seven oxycodone 5 mg tabs were removed from the narcotic count electronic system.

Resident B's Medication Disposition Record, provided by the Administrator, on 5/29/26 at 10:25 a.m., indicated seven oxycodone were destroyed on 5/26/26.

During an interview, on 5/28/26 at 2:05 p.m., QMA 17 indicated that Resident B's narcotic count was consistently incorrect for oxycodone (narcotic pain medication) and Norco (narcotic pain medication). On 5/20/26 at 4:00 p.m., there was no QMA to relieve her and a narcotic count was not completed. When there was no oncoming QMA, she normally placed the medication cart keys in a combination locked filing cabinet drawer

located in the medication room or completed a narcotic count with the DON. On 5/20/26, as she placed the keys in the filing cabinet drawer, QMA 32, who did not normally work as a QMA, took the keys. When QMA 17 returned to work on 5/21/26 at 6:00 a.m., Resident B's discontinued oxycodone, remained in the narcotic box, and the Norcos were missing. Neither medication appeared in the electronic narcotic count system. She attempted to enter the Norco count into the EHR (electronic health record) but received error messages when entering three pills from the blister card of Resident B's previous as needed prescription, then totaled the two and entered 15 pills, and then 12 pills from the bottle. QMA 45 had completed the narcotic count with her on 5/20/26 and again on 5/21/26 at 6:00 a.m. She reported the missing medications to the DON on 5/21/26 and wrote the information on a Post-it note as a reminder to the DON. All staff had access to the medication room, the medication cart was normally locked, and only the QMAs had the combination to the filing cabinet lock.

During an interview, on 5/29/26 at 10:00 a.m., the DON indicated that the oxycodone was marked as discontinued in

the system on 5/20/26 due to Resident B being in and out of the hospital for fractures that were close together. The oxycodone remained in the drawer after being discontinued because the DON came from Long Term Care and believed she needed another nurse to destroy medication and she had not learned until recently that she could destroy medication with a QMA. The oxycodone was destroyed on 5/26/26.

A current facility policy, dated 6/10/24, titled "Medication Disposal and Destruction," provided by the Administrator on 5/28/26 at 1:11 p.m., indicated the following: "...Procedure...4. Disposal and Destruction of Controlled Substances: a. When controlled medications are to be destroyed, the medications will be destroyed in the Community by the Director of Health and Wellness or Nurse/QMA, and one (1) additional adult who is an employee. b. Controlled Substance medication(s) will be disposed of in a medical waste receptacle in accordance with the manufacturer's instructions. i. Both parties MUST witness the destruction. c. The Director of Health and Wellness or Nurse/QMA, and the additional adult witness will document the disposal/destruction on the Medication Disposition Record. i. Both individuals will sign the

	Medication Disposition Record...." This citation relates to Intake 469882.			

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 SIGNATUREKimberly Bennett	TITLEDivision Director of Resident Care	(X6) DATE06/19/2026