STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/20/2023

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: November 20, 2023. Facility number: 003376 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 21, 2023	R 0000		
R 0034 Bldg. 00	410 IAC 16.2-5-1.2(i) Residents' Rights - Noncompliance (i) The facility will distribute to each resident upon admission the state developed written description of law concerning advance directives. Based on observation and interview, the facility failed to ensure a resident's medication was stored securely during a random observation. This deficient practice had the potential to effect 21 of 21 residents who resided in the facility and utilized the activity room. Findings include: During the initial tour of the facility, on 11/20/23 at 8:51 a.m., two drawers at the bottom of the activity room refrigerator contained the following items for Resident 49: a. Two closed boxes of Trulicity (lowers blood sugar) with four pens in each box.	R 0034	**R 034 410 IAC 16.2-5-1.2(i) Residents' Rights – Noncompliance** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The items were immediately removed and placed in the proper storage area on 11/20/23. **2 How the facility will identify other residents having the potential to be affected by**	12/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Quinn	Executive Director	12/08/2023

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	b. Three closed boxes of Lantus (insulin) with five prefilled pens in each box. c. Six closed boxes of Humalog (insulin) Kwik pens with two prefilled pens in each box. QMA 17 entered the activity room and indicated she was not aware of the medication being in the refrigerator. Resident 49 administered her own medication and may have ran out of room in the refrigerator in her room and put them in the activity room refrigerator. Medications are normally stored in the nursing office. She indicated all residents had acces to and utilized the activity room. A current facility policy, dated 9/1/16, titled, "Storage of Medication," provided by the Administrator, on 11/20/23 at 3:58 p.m., indicated the following: "Process...Medications requiring refrigeration should be stored separately in the Med Room refrigerator...."		**the same deficient practice and what corrective action will be taken:** An audit of the activity room refrigerator was performed on 11/21/23 by Executive Director (ED), to ensure no other medications were being stored in the activity refrigerator. **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:** Resident 49 was educated on proper medication storage. Activity Director and Housekeeper were retrained on 12/7/23, by Executive Director, that medications cannot be stored in the activity refrigerator. All staff will be retrained on proper medication storage by 12/15/23. **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 12/11/23, the ED or designee will audit the activity refrigerator weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure that medications are not being improperly stored. The	

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			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:** 12/15/23	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure kitchen cabinetry was maintained in good condition to prevent contamination of dishes, food, and equipment. This deficient practice had the potential to effect 21 of 21 residents who received meals from the facility kitchen. Findings include: During the kitchen tour on 11/20/23 at 8:44 a.m., accompanied by Cook 73, the following was observed: On the west side of the kitchen island counter, a drawer was missing its outer face and the inner box had fallen off of the track, causing it to lay on top of plastic storage containers and lids. Debris from the drawer's particle board was scattered on the shelving, on top of dark staining and a sticky	R 0154	**R 154 410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards – Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Kitchen cabinets have been scrubbed out/down to ensure cleanliness/proper sanitation, Items stored in drawers have been consolidated and the broken drawers have been taken out of use, Peel and stick-type molding was removed from kitchen and proper caulking was applied after the area was cleaned, The kitchen	12/08/2023

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	substance under the plasticware. Inside another drawer, containing storage bags and miscellaneous supplies, several piles of brown crumbs and debris were present in the corners and on the floor of the drawer. The cabinet below, containing boxes and bags of dry cereals and oatmeals, had grime and a sticky substance on the shelves. Staining and a sticky substance was present to the inside of the cabinet doors. On the east side of the kitchen island counter, a drawer was missing its outer face and debris had fallen to the shelves below. Two additional drawer faces were screwed on with large, dark screws; one drawer was screwed shut. The shelves inside the cabinets, containing pitchers and carafes, had scattered grime, staining, and debris on them. An additional drawer lacked a pull, requiring it be opened from it's bottom, causing debris to fall onto the shelves below. Staining and a sticky substance was present to the inside of the cabinet doors. The countertop on the south side of the kitchen had a flexible, peel and stick-type moulding along the wall, which was detached and rippled, with debris present on top and underneath it. Plastic wrap and aluminum foil tubes were situated just beneath the moulding strip. The window ledge above the counter and food wraps had a fine layer of dust and debris on it. The faucet handles for the sprayer near the dish machine had a black substance surrounding the base, and had an accumulation of caulking around the base, partially covering the black substance. During an interview, at the time of the observations, Cook 73 indicated the cabinets were in poor repair.		window sills/ledges were cleaned, The kitchen faucet for the dish sprayer was removed, properly cleaned, and properly caulked. These items were addressed by 12/8/23. **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 audit of the kitchen findings was performed by Executive Director (ED) and Director of Facilities (DOF) on 11/23/23. A cleaning/repair list was produced with assignments for the appropriate staff to perform duties. **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 Executive Chef was retrained on 12/8/23 on ensuring work orders are processed for items needing repair/reporting concerns noted regarding cleaning/sanitation matters in the kitchen. The Director of Facilities was retrained on 12/8/23 on ensuring work orders are processed in a timely manner. **4 How the corrective**	

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	Review of a current, posted, facility document titled "Daily, Weekly, Bi-Monthly Kitchen Cleaning Checklist," indicated to clean the front of the cabinets daily.		**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 12/11/23, the ED or designee will audit the kitchen environment for repair needs and sanitation. The audits will be performed weekly x 4 weeks, biweekly x 4 weeks, then monthly. 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:** 12/8/23	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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 appropriate to the: (A) scope; (B) frequency;			

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	(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 5 of 7 residents reviewed for service plans. (Residents 21, 13, 41, 49, and 29) 1. Review of Resident 21's clinical record was completed on 11/20/23 at 10:55 a.m. Diagnoses included diabetes type 2 and hemiplegia. Review of the resident's current, 9/1/23, service plan indicated it lacked a summary of the service fee and who it was reviewed with. The document lacked a signature of the resident's legal representative. 2. Review of Resident 13's clinical record was completed on 11/20/23 at 11:41 a.m. Diagnoses	R 0217	**R 217 410 IAC 16.2-5-2(e)(1-5) Evaluation – Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 29 & 41 are no longer reside at our community. Service plans for Residents 49, 21, 13 have been reviewed with the resident and/or are waiting for Responsible Party. **2 How the facility will identify other residents having the potential to be affected by**	12/08/2023

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	included anxiety, depression, and Parkinsonism. Review of the resident's current, 11/6/23, service plan indicated it lacked a summary of the service fee and who it was reviewed with. The document lacked a signature of acknowledgement from the resident. 3. Review of Resident 41's closed clinical record was completed on 11/20/23 at 12:17 p.m. Diagnoses included coronary artery disease and chronic kidney disease. Review of the resident's most current, 9/3/23, service plan indicated it lacked a summary of the service fee. The document lacked a signature of the resident's legal representative. 4. Resident 49's clinical record was reviewed on 11/20/23 at 10.49 p.m. Diagnoses included atrial fibrillation, diabetes type 2, heart failure, hypotension, coronary angioplasty implant and graft and insomnia. Her service plan was dated 11/1/23, signed by the DON on 11/1/23 and the Administrator on 11/3/23. The service plan was not signed by the resident or her representative. 5. Resident 29's closed clinical record was reviewed on 11/20/23 at 12:01 p.m. Diagnoses included hypertension, hyperlipidemia, depression and dementia. Her service plan was dated 9/1/23 and signed by the DON on 9/1/23. The service plan was not signed by the resident or her representative. During an interview, on 11/20/23 at 1:00 p.m., the interim DON indicated service plans should be reviewed and signed by the resident or their		**the same deficient practice and what corrective action will be taken:** Audit of all resident service plans was completed by Director of Health & Wellness on 12/8/23. **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:** On 12/8/23, the Executive Director and new Director of Health & Wellness were trained by the Division Director of Resident Care 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 12/11/23, 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. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is	

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	representative. A current facility policy, revised on 12/15/17, titled "Envilant Service Assessment Interpretive Guidelines," provided by the Administrator, on 11/20/23 at 3:58 p.m., indicated the following: "...Be familiar with you state regulations regarding Service Plans...."		necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed:** 12/8/23	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (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. Based on observation, interview, and record review, the facility failed to ensure the kitchen was maintained in a sanitary manner. This deficient practice had the potential to effect 21 of 21 residents who received meals from the facility kitchen. Findings include: During the kitchen tour on 11/20/23 at 8:44 a.m., accompanied by Cook 73, the following was observed: A rusted manual food masher was in a cabinet above the microwave area. The ice machine had a red, slimy substance surrounding the bolts inside the storage area, touching the ice. Inside the vegetable refrigerator, a box contained heads of iceberg lettuce, which were browned and wet at the stems, and the leaves were wilted, wet	R 0273	**R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services – Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The manual food masher was disposed of, the ice machine was emptied/scrubbed/sanitized, the lettuce of concern was disposed of, the fire dampers and ceiling vents have been cleaned, the floor in the kitchen and food pantry are scheduled for professional steam cleaning on 12/8/23. All items have been resolved as of 12/8/23. **2 How the facility will**	12/08/2023

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	and brown. The fire dampers above the kitchen island had a moderate amount of grime and dust on them. The ceiling vent above a cart with stacked, clean dishes had a moderate amount of brown rust and grime. The floors had a dark, grimy cast to them, with a blackened substance accumulated in the corners and edges, and scattered debris over the entire floor. During an interview, at the time of the observation, Cook 73 indicated there was a cleaning schedule posted for the kitchen. The facility had been serving the lettuce, but would dispose of it today since the new order came in. Review of a posted kitchen cleaning schedule indicated the kitchen floor should be swept and mopped every night.		**identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of the kitchen findings was performed by Executive Director (ED) and Director of Facilities (DOF) on 11/23/23. A cleaning/repair list was produced with assignments for the appropriate staff to perform duties. **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 Executive Chef was retrained on 12/8/23 regarding when to throw out food items, cleaning/sanitation, reporting items that need cleaned/sanitized/repaired. n the kitchen. The Director of Facilities was retrained on 12/8/23 regarding cleaning/sanitation. **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 12/11/23, the ED or designee will audit the kitchen coolers to ensure no food items	

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			need to be disposed of and that the kitchen/equipment is clean. The audits will be conducted 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:** 12/8/23	