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	08/04/2022

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: August 3 and 4, 2022. Facility number: 003376 Residential Census: 25 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 8, 2022.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or 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.*	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure monthly fire drills were completed. Findings include: On 8/3/22 at 9:35 a.m., fire drills were requested during the entrance conference. On 8/3/22 at 2:07 p.m., the Executive Director indicated the Maintenance Director quit last week and they are unable to find the binder with the fire drills in it. When she realized it, she completed a fire drill on 7/29/22. On 8/3/22 at 2:17 p.m., the Executive Director indicated as she looked for the ventilation inspections, she ran across some fire drills and provided fire drills dated 2/28/22, 3/15/22, 4/11/22, 6/24/22, 7/22/22. On 8/4/22 at 11:19 a.m., the DON indicated they were unable to find the rest of the fire drills. A current policy, titled "Crisis Prevention Policy," provided by the DON, on 8/4/22 at 11:56 a.m., indicated the following: "...Procedure: 2.) Fire Drills will be performed on a monthly basis and include rotating shifts to ensure each shift completes a fire drill once per shift per quarter,	R 0092	**R 092 Administration and Management – Noncompliance** ="" b="">
="" p="">
A fire drill was completed on 8/19/2022 by the Executive Director (ED). An audit of fire drills for the last 12 months was completed on 8/17/2022 by the ED to ensure fire drills are conducted quarterly on each shift and at least twelve drills are held every year.Results review with the Regional Director of Facilities Management (RDFM) and schedule created for drill completion for the remainder of 2022. The Executive Director was re-educated on 8/12/2022 by the Regional Director of Care Services (RDCS) on the need to ensure fire drills are conducted quarterly on each shift and at least 12 drills are held every year. Effective 9/5/2022, the ED or designee will audit fire drill logs weekly x 4 weeks, biweekly x 4 weeks, then monthl to ensure fire	09/04/2022

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	and to ensure employee understanding of fire safety...."		drills are conducted quarterly on each shift and at least 12 drills are held every year. Audit results will be reviewed at monthly QI meeting. The QI Committee will determine if continued audits are necessary based on 3 consecutive months of compliance. Monitoring will be on-going Completion date: 9/4/2022	
R 0117 Bldg. 00	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. Based on record review and interview, the facility	R 0117	**R 117 Personnel – Deficiency**	09/04/2022

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	failed to ensure an awake employee was present in the facility at all times for 11 full shifts and four half-shifts of 36 shifts reviewed. Findings include: Review of schedules from 7/22/22 through 8/2/22 indicated the following: The facility lacked an employee present with first aid training on second shift six times for the entire shift and four times for half of the shift. The facility lacked an employee present with first aid training on third shift five times for the entire shift. During an interview, on 8/4/22 at 10:29 a.m., the Care Services Manager Nurse (CSM) and the Administrator indicated they both work on the facility schedule. The CSM indicated she was responsible to ensure they had a staff member with both CPR and First Aid training present at all times. The Administrator indicated they thought the agency staff were both CPR and First Aid trained, but had not confirmed this. Review of a current facility policy titled "First Aid Policy," dated 3/1/22 and provided by the CSM on 8/4/22 at 11:56 a.m., indicated the following: "...Staff members will be required to be first aid certified in states which require employees to obtain and maintain certification based on the state regulatory requirements...."		=" " span<=" " b1.=" "> =" " span=" "> First aid training was completed for current second and third shift staff on 8/17/2022 by the Executive Director and Care Services Manager. =" " span=" ">An audit of staff first aid certifications was completed on 8/18/2022 by the Executive Director (ED) to ensure one awake staff person, with current first aid certification, is on site at all times. Employees without current first aid certification will obtain certification by 9/4/2022. The current staffing schedule was reviewed on 8/19/2022 by the ED to ensure a first aid certified employee is scheduled and on site at all times The ED was re-trained on 8/12/2022 by Regional Director of Care Services regarding the need to ensure one awake staff person, with current first aid certification, is on site at all times. Effective 9/5/2022, the ED or designee will audit the staffing schedule weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure a first aid certified employee is on site at all times. 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.	

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R 0144 Bldg. 00	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. Based on observation and interview, the facility failed to ensure carpeting was clean and in good repair in common areas and resident rooms. Findings include: During an initial tour of the facility, on 8/3/22 at 10:11 a.m. indicated the following: The private lounge/entertainment room had scattered, dark stains to the carpet, near the T.V. stand. A large rectangular stain was present to the carpet outside the north doorway to the main dining room, with a streaked area in the center of the soiled area. Long, linear dark stains ran from near the northern dining room doorway to the employee lounge and southwest egress door. The carpet in front of both doors was soiled with dark stains. Room 130's door was open and had a large discoloration in front of the sink, approximately the size of a card table. There were scattered, dark circular stains down the northern and eastern hallways. The eastern hallway also had a large stain near room 112, approximately the size of two card tables.	R 0144	Completion date: 9/4/2022 **R 144 Sanitation and Safely Standards – Deficiency** The carpet in common areas, room 126, and room 130 was cleaned on 8/18/2022 by an outside vendor. An observational audit of the carpet in common areas and resident rooms was completed on 8/18/2022 by Executive Director (ED) to ensure carpeting is clean and in good repair. Rooms 104, 116, 117, 121, 1227, 128 and the wellness office were identified as needing cleaned. The cleaning was completed on 8/18/202 by an outside vendor. /p> ="" span ="" span="">The ED was re-trained on 8/12/2022 by Regional Director of Care Services regarding the need to ensure carpeting is clean and in good repair in common areas and resident rooms. ="" span="">Effective 9/5/2022, the ED will complete observational audits of the carpet in common areas and resident rooms weekly	09/04/2022

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	The carpet in front of both the housekeeping and the soiled utility rooms had dark stains to the thresholds. During a medication administration observation, on 8/3/22 at 3:40 p.m., a large dark stain was observed in the center of Room 126. During an interview, on 8/4/22 at 11:03 a.m., the Care Services Manager Nurse indicated part of the carpeting had been cleaned professionally the prior week, but was restricted to the front of the building and one resident room. The facility's carpet cleaning machine was not operational.		x 4 weeks, biweekly x 4 weeks, then monthly to ensure carpeting is clean and in good repair in common areas and resident rooms. 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. Completion date: 9/4/2022	
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to ensure pharmacist recommendations were addressed with a medical provider for 3 of 6 residents reviewed for pharmacy recommendations (Residents 4, 8, and 9). Findings include: 1. Resident 4's record was reviewed on 8/3/22 at 10:56 a.m. Diagnoses included, but were not limited to, CVA with right hemiparesis, Parkinsonism, and hypertension. Review of a 5/26/22 pharmacist recommendation document indicated the resident was receiving clonidine (blood pressure) 0.1 mg twice daily. The recommendation noted the drug class of the blood pressure medication should be avoided in the elderly due to increased risk of orthostatic	R 0299	R 299 Pharmaceutical Services – Noncompliance The pharmacist recommendation for Resident 4 was addressed with the primary care provider by the Care Services Manager (CSM) on 8/19/2022. The pharmacist recommendation for Resident 8 was addressed with the primary care provider by the CSM on 8/16/2022. The recommendation was accepted. The pharmacist recommendation for Resident 9 was addressed with the primary care provider by the CSM on 8/19/2022. An audit of pharmacist recommendations for the last 60 days was completed on 8/19/2022	09/04/2022

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	hypotension (low blood pressure when changing positions). The clinical record lacked indication the recommendation was reviewed by a medical provider. 2. Resident 8's clinical record was reviewed on 8/3/22 at 2:17 p.m. Diagnoses included, but were not limited to, hemiplegia and diabetes type 2. Review of a 3/28/22 pharmacist recommendation indicated his tamsulosin (prostate medication) 0.4 mg could increase his risk for hypotension and falls, and requested it be evaluated to adjust the time of administration. The clinical record lacked indication the recommendation was reviewed by a medical provider. 3. Resident 9's clinical record was reviewed on 8/3/22 at 2:21 p.m. Diagnoses included, but were not limited to, congestive obstructive pulmonary disease, tachycardia and congestive heart failure. Review of a 5/26/22 pharmacist recommendation indicated she had an order for diphenhydramine every 12 hours as needed and to consider discontinuing it if appropriate due to diphenhydramine had a strong, sedating anticholinergic properties with decreased clearance in advanced age and should be avoided in the elderly. The clinical record lacked indication the recommendation was reviewed by a medical provider. During an interview, on 8/4/22 at 10:36 a.m., the Care Services Manager indicated pharmacy		by the CSM to ensure pharmacist recommendations were addressed with a medical provider. No issues identified. The CSM was retrained on 8/12/2022 by the Regional Director of Care Services on the need to ensure pharmacist recommendations are addressed with a medical provider. ="" span="">Effective 9/5/2022, the CSM or designee will audit pharmacist recommendations weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure pharmacist recommendations are addressed with a medical provider. 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. Completion date: 9/4/2022	

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	recommendations should be reviewed by the Nurse Practitioner after they were placed in her folder. She was not able to find evidence the reviews had been completed for Residents 4 and 8. A facility policy for pharmacist recommendations was requested from the Care Services Manager Nurse on 8/4/22 at 10:30 a.m., but was not provided prior to exit conference.			
R 0350 Bldg. 00	410 IAC 16.2-5-8.1(b)(1-2) Clinical Records - Noncomformance (b) Clinical records must be retained after discharge: (1) for a minimum period of one (1) year in the facility and five (5) years total; or (2) for a minor, until twenty-one (21) years of age. Based on interview, the facility failed to ensure a clinical record was maintained at the facility after a discharge of the resident (Resident 6). Findings include: A report, titled "Move-In/Move-Out Activity Summary by House," provided by the Executive Director, on 8/3/22 at 10:25 a.m., indicated Resident 6's rent-effective date was 4/29/22 and he was discharged on 5/6/22. On 8/3/22 at 4:00 p.m. Resident 6's closed clinical record was requested. During an interview, on 8/4/22 at 11:19 a.m., the DON indicated that they were unable to locate the resident's chart. He was only at the facility for two days and discharged to a local skilled nursing facility because he was not appropriate for assisted living. They had an Interim Executive	R 0350	**R 350 Clinical Records – Nonconformance** ="" span="">The clinical record for resident 6 could not be located ="" span="">An audit of clinical records for residents discharged in the last 90 days was completed on 8/19/2022 by the Care Services Manager (CSM) to ensure clinical records are retained after discharge for a minimum period of 1 year in the community and 5 years total. No concerns identified. ="" span="">="" span="">The CSM was retrained on 8/12/2022 by the Regional Director of Care Services on the need to ensure clinical records are retained after	09/04/2022

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	Director during that time and was not sure where the chart went. A current policy, titled "Resident Record Retention Policy," provided by the DON, on 8/4/22 at 11:56 a.m., indicated the following: "...Procedure: 1. Closed resident files will be retained for the specified amount of time based on each state regulatory requirement...."		discharge for a minimum period of 1 year in the community and 5 years total. Discharged resident records will be stored in the medical records storage room in the community. ="" span="">Effective 9/5/2022, the CSM or designee will audit clinical records for discharged residents weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure clinical records are retained after discharge for a minimum period of 1 year in the community and 5 years total. 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. Completion date: 9/4/2022	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (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			

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	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 resident received a second-step PPD test (for tuberculosis screening) for 1 of 6 residents reviewed for tuberculin testing (Resident 4). Findings include: Resident 4's record was reviewed on 8/3/22 at 10:56 a.m. Diagnoses included, but were not limited to, CVA with right hemiparesis, Parkinsonism, and hypertension. A first step PPD test was placed on 3/23/22 and read on 3/25/22. The clinical record lacked a second-step test. During an interview, on 8/3/22 at 10:29 a.m., the Care Services Manager Nurse indicated the second-step test had not been completed. Review of a current facility policy titled "Tuberculosis (TB) Testing Policy," dated 3/1/22 and provided by the Care Services Manager Nurse on 8/4/22 at 11:56 a.m., indicated the following: "...Tuberculosis testing will be completed per state regulations for residents...."	R 0410	**R 410 Infection Control – Noncompliance** Resident 4 received a first step tuberculin skin test (TST) on 8/12/2022 administered by the Care Services Manager (CSM). The second step TST was administered by the CSM on 8/19/2022. ="" p="">An audit of resident TST's was completed on 8/19/2022 by the CSM to ensure residents receive a TST within 3 months prior to admission or upon admission and if negative, a second step TST if no documented negative TST in the preceding twelve months. Any issues identified were corrected. The CSM was retrained on 8/12/2022 by the Regional Director of Care Services on the need to ensure residents receive a TST within 3 months prior to admission or upon admission and if negative, a second step TST if no documented negative TST in the preceding twelve months. ="" p="">Effective 9/5/2022, the CSM or	09/04/2022

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			designee will audit resident tuberculin skin test records weekly x 4 weeks, biweekly x 4 weeks, then monthly to ensure residents receive a TST within 3 months prior to admission or upon admission and if negative, a second step TST if no documented negative TST in the preceding twelve months. 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. Completion date: 9/4/2022	