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	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLNSHIRE PLACE - MUNCIE	1600 N MORRISON ROAD MUNCIE, IN 47304

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: January 19 and 20, 2023 Facility number: 014463 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 24, 2023.	R 0000		
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alyssa Butterfield	Administrator In Training	02/05/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	appropriate. Based on observation and interview, the facility failed to post the contact information and addresses of local health and human services agencies in an accessible area. This deficient practice had the potential to impact 26 of 26 residents. Findings include: During the initial tour of the facility, on 1/19/23 at 10:30 a.m., contact information for health and human services agencies were not posted in the facility. During a random observation, on 1/20/23 at 10:00 a.m., contact information for health and human services agencies were not posted in the facility. During an observation and interview, on 1/20/23 at 10:02 a.m., the AIT (Administrator in Training) indicated the facility only had the Ombudsman services posted. She was unaware more advocacy agencies' information needed to be posted. The facility did not post the most recently known addresses and telephone numbers of the following advocacy agencies: a. The Indiana Department of Health. b. The office of the Secretary of Family and Social Services. c. The Area Agency on Aging. d. The local mental health center. e. Adult Protective Services.	R 0033	R033 What Corrective action will be accomplished for those residents found to have been affected by the deficient practice? *The phone numbers and addresses for the following agencies were posted prior to survey team exit.* How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected.* What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? *Phone Numbers and addresses will be audited 1x a month for 3 months, Every other Month for 3 Months, 2x's yearly thereafter.* How the corrective action will be monitored to ensure deficient practice will not recure? *Phone Numbers and Addresses will be audited by the Administrator or designee.* By what date the Systemic Changes will Be completed. *February 5th 2023*	02/05/2023
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the			

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	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; (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 interview and record review, the facility failed to ensure service plans were signed by a resident and/or their representative for 5 of 7 clinical records reviewed. (Residents 6, 11, 27, 20 and 9) Findings include: 1. Resident 6's clinical record was reviewed on 1/19/23 at 11:14 a.m. Current diagnoses included dementia, hypertension, and hypothyroidism.	R 0217	What Corrective action will be accomplished for those residents found to have been affected by the deficient practice? *Nursing staff will be in-service and all Resident Service Plans will be signed by the resident/representative within 1 week of move in according to facility policy* How will the facility identify other	02/05/2023

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	The resident had a service plan dated by a nurse on 2/15/22. This service plan was not signed by the resident and/or their representative. The record lacked any service plan that had been signed by the resident and/or their representative. 2. Resident 11's clinical record was reviewed on 1/19/23 at 10:52 a.m. Current diagnoses included dementia, schizoaffective disorder, and hypothyroidism. The resident had a service plan review dated by a nurse on 10/20/22. The resident had a service plan completed 4/21/22. The 4/21/22 service plan was not signed and dated by the nurse who completed it. Neither the service plan or service plan review were signed by the resident and/or their representative. The record lacked any service plan that had been signed by the resident and/or their representative. 3. Resident 27's closed clinical record was reviewed on 1/19/23 at 12:53 p.m. Discharge diagnoses included dementia, hypertension, and hypothyroidism. The resident had a service plan dated by a nurse on 11/10/22. This service plan was not signed by the resident and/or their representative. The record lacked any service plan that had been signed by the resident and/or their representative. The resident had discharged from the facility on 12/20/22. During an interview, on 1/19/23, 11:34 a.m., the Director of Nursing (DON) indicated she had become the DON in December of 2022. She had just identified that the previous DON had not ensured service plans were signed by the resident		residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected. The Director of Nursing will audit all service plans for signatures and will obtain signatures on the current service plans for all residents that do not currently have a signature.* What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? *Service Plans will be signed within 1 week of move in by the resident/representative according to facility policy.* How the corrective action will be monitored to ensure deficient practice will not recure? *The Director of Nursing/designee will audit the resident service plans 1x weekly for 4 weeks, 2x's monthly for 3 months, and 1x monthly thereafter.* By what date the Systemic Changes will Be completed. *February 5th 2023*	

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	or their representative. If the surveyor found during reviews that the resident did not have a signed service plan, the facility did not have a signed plan to provide for these residents. 4. Resident 20's clinical record was reviewed on 1/19/23 at 12:53 p.m. Diagnoses included Alzheimer's Disease, anxiety, depression, hypertension, diabetes mellitus, renal failure and back pain. Review of the resident's service plan, dated 3/5/22, lacked a resident or resident representative signature. This service plan had a change in the code status and medication administration from the previous signed service plan dated 3/13/21. During an interview, on 1/19/23 at 1:56 p.m., the DON indicated Resident 20's current service plan was unsigned by the resident or resident representative. 5. Resident 9's clinical record was reviewed on 1/20/23 at 10:30 a.m. Diagnoses included end stage heart failure, cardiac pacemaker, hypertension, ischemic cardiomyopathy, paroxysmal atrial fibrillation and chronic kidney disease. Review of the resident's service plan, dated 9/29/22, lacked a resident or resident representative signature. The clinical record lack any service plans signed by the resident or resident representative. During an interview, on 1/20/23 at 11:13 a.m., the DON indicated Resident 9's service plan was unsigned by the resident or resident representative. During an interview, on 1/20/23 at 11:22 a.m., the			

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	Administrator in Training (AIT) indicated copies of signed service plans were not available for Resident 20 and Resident 9. Review of a current, undated, facility policy titled "Initial Service Plan," provided by the AIT on 1/19/23 at 3:08 p.m., indicated the following: "...A licensed nurse and the Lincolnshire team, will identify and document the services to be provided by the facility, and include scope of services, frequency, need and preferences of the resident...The service plan will be agreed upon by the resident/representative, signed and dated by the resident or responsible party, and a copy of the service plan shall be given to the resident or responsible party upon request. The service plan must be in place within one week of moving in. 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/responsible party may request a service plan review...."			
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 maintain kitchen equipment in a clean, safe, sanitary manner. This deficient practice had the potential to impact 26 of 26 residents who received their meals from the facility kitchen. Findings include: During a kitchen observation, on 1/19/23 at 9:58	R 0273	What Corrective action will be accomplished for those residents found to have been affected by the deficient practice? *Dietary staff will be in serviced on the facility cleaning policy and dietary cleaning checklist. Food contact surfaces of grills, griddles, stove tops, and other similar cooking devices will be cleaned at*	02/05/2023

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	a.m., the following concerns regarding kitchen cleanliness were observed: a. The griddle attached to the large kitchen stove had a heavy, burnt blackish/brown residue covering the back-splash. b. The drip pan, located under the burners on the stove, was covered with brown burnt on liquids and particles of food over the entire pan surface. c. The two (2) ovens anterior doors had brown, yellow and black baked and burnt food residue. The bottom of the oven had overflowed burnt food on it. During an interview, on 1/19/23 at 10:10 a.m., the Dietary Manager indicated the drip pans, ovens, and griddle should be cleaned at least once a week. The griddle, oven and drip pan did not appear to have been cleaned in the last week. She did not have a written cleaning schedule which identified what cleaning task should be completed when. She had a previous schedule but failed to print new forms out when needed. A current, undated and untitled facility dietary document, provided by the AIT on 1/19/23 at 3:19 p.m.., indicated the following: "...Good cleaning practices must be followed during and after food preparation and service...Food contact surfaces of grills, griddles, stove tops,and other similar cooking devices...will be cleaned at least once daily...."		*least once daily according to facility policy.* How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *All residents have the potential to be affected* What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? *Dietary Staff will complete all tasks on the cleaning checklist daily.* How the corrective action will be monitored to ensure deficient practice will not recure? *The kitchen surfaces and cleaning checklists will be audited by the Administrator/Designee 2x's weekly for 4 weeks, 1X weekly for 4 weeks and then monthly thereafter.* By what date the Systemic Changes will Be completed. *February 5th 2023*	