DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: November 21 and 22, 2024 Facility number: 014463 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 26, 2024.	R 0000		
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency Based on observation and interview, the facility failed to ensure dignity was maintained during meal service for 3 of 3 residents reviewed for dining services. (Residents 11, 16, and 37) Findings include: During a dining observation on 11/21/24, at 12:08 p.m., Residents 11 and 16 were observed at a corner dining table awaiting food service. Two staff members were delivering drinks and meals to residents. Resident 11 and 16's meals were delivered at approximately 12:10 p.m. The meals were out of reach for both residents while they each sat in Broda chairs (a wheelchair designed to help a resident maintain an upright position). The position(s) of their chairs did not allow them to reach their plates or drinks. The plates and drinks	R 0029	R029 1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency. **·Resident 11, 16 and 37 are now served with meals within reach. If the resident is in a wheelchair the chair is set up to the most upright position as close to the table as possible. Staff are serving residents and then immediately feeding them and using proper communication while feeding.** 2.Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client	01/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alyssa Butterfield	Executive Director	12/13/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were directly in front of each resident, and the residents at other tables were already eating their meals. At 12:16 p.m., CNA (certified nursing aide) 8 donned gloves and prepared to assist Resident 11. CNA 8 instead assisted Resident 37, who was sitting at another table, to move to the same table as Residents 11 and 16. At 12:20 p.m., CNA 7 moved Resident 16's plate closer. Resident 16 could move his arms and could reach towards the plate. Resident 16 picked up a potato chip and placed it in his mouth. At 12:24, the resident remained in front of his meal and no assistance had been offered by staff. During this time, neither CNA 8 nor CNA 7 spoke to Resident 16. CNA 8 provided food to Resident 37. CNA 7 sat down next to Resident 11 and began assisting him at 12:25 p.m. CNA 7 did not make eye contact with, nor speak to, Resident 11. The CNA offered food in a rushed manner. The two CNAs engaged in conversation with one another about a resident at another table and how they would like to shave his beard. At approximately 12:26 p.m., Resident 16 was observed feeling around the top of the table, trying to find his plate. CNA 7, who was seated next to Resident 16, did not engage with the resident. CNA 7 continued to talk with CNA 8 as they assisted the other residents. At 12:40 p.m., Resident 16 had not been offered any food or drink. The discussion at the table at that time, between CNA 7 and CNA 8, centered on what they were planning to buy at the store. At 12:49 p.m., Resident 11 had finished their meal. CNA 8 began to assist Resident 16. The CNA offered him bites of his food, but did not provide		the facility identified as being affected. **·Resident service plans were reviewed to determine all residents that need assistance with feeding. All residents who need assistance with feeding have the potential to be affected those residents are only the residents listed above.** 3.Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. **·All Staff will be in-serviced on a dignified dining experience and the facility feeding policy and residents rights by January 8th 2025. Staff will also be in-serviced on how to properly serve meal trays to residents.** 4.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **·The Director of Nursing will monitor meals times 3x a week for 2 months and then monthly thereafter for a total of 6 months to ensure residents are given a dignified dining experience and residents rights are being maintained.**	

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

eye contact or conversation. The CNA instructed him to take a bite. When she offered a drink, she told the resident "Here, have a drink".

On 11/22/24 at 12:07 p.m., both Resident 11 and Resident 16 had their plates and drinks on their table. Two plates and 3 drinks were sitting towards the edge of the table, across from and out of reach from both residents. The food and drinks were in front of both of the residents.

At approximately 12:15 p.m., Resident 11 and Resident 16 were awaiting assistance with their meals. The grilled cheese sandwiches, soup, and potato chips had been sitting at the table for approximately 8 minutes.

At 12:22, CNA 6 began to provide assistance for Resident 16. She stood next to his chair and offered him a drink and a bite of his sandwich. At 12:22 p.m., she moved to Resident 11, stood next to his chair, and offered him some soup. Resident 16 was holding a piece of sandwich, but not eating it. CNA 5 approached the table, donned gloves, and began to assist Resident 16 with the bite of food still in his mouth. He had just started to chew when she picked up a potato chip and offered that to him. Both CNAs sat down and continued to assist the residents. Conversations consisted of the instructions "Take a bite" and "Here is some soup". During this exchange, CNA 5 was observed to look at the other CNA, roll her eyes, and shake her head in frustration.

At 12:30 p.m., CNA 6 made no eye contact with Resident 11 as she waited for the resident to finish with his last bite and then she would offer another.

At 12:25 p.m., CNA 5 got up from the table, went

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

into a resident's room nearby, had a discussion with that resident, returned, and provided fresh drinks for several other residents. Resident 16 sat without any assistance with his meal.

At 12:31 p.m., CNA 5 returned to assist Resident 16 with his meal.

During an interview on 11/22/24 at 1:54 p.m., the DON indicated CNAs received feeding training during their Certified Nursing training. She did not think any in-services on feeding training had been provided in the last year.

During an interview with CNA 6, on 11/22/24 at 2:40 p.m., she indicated conversations with residents were supposed to be like any "regular" conversation. CNAs were supposed to ask the residents if they would like a drink or a bite of food. Resident 16 had Parkinson's disease and could move his arms, but had trouble getting the food to his mouth. Resident 11 also had trouble with keeping his food on his fork or spoon, but sometimes did take bites on his own.

During an interview with the DON, on 11/22/24 at 2:46 p.m., she indicated standing next to a resident to feed them was not appropriate unless there was difficulty in reaching the resident to feed them. It would depend on the height of the chair and the length on the CNA's arms. CNAs should not discuss outside issues in front of the residents. CNAs should look at the residents and talk to them directly.

An untitled, undated facility policy, provided by the DON on 11/22/24 at 1:55 p.m., indicated the following: "...Assisting Residents with Dining: On occasion residents may need help with all or portions of a meal. (The facility) strives to provide

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that aid while maintaining dignity and promoting independence...Independence and dignity must always be preserved while assisting residents with meals...."			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure newly employed had 6 hours of dementia training within 6 months of hire, long standing employees had 3 hours on annual dementia training, and inservice training records contained information required by state rules for 6 of 6 employee records reviewed (RN 9, CNA 10, CNA 11, Maintenance 12, CNA 13, and CNA 14). Findings include: Employee records were reviewed on 11/21/24. The following concerns were identified: a. New hire- RN 9, hired 3/15/24 - lacked documentation of 6 hours of dementia training completed within 6 months of hire. b. New hire- CNA 10, hired 5/31/24 -lacked documentation of 6 hours of dementia training completed within 6 months of hire. c. New hire- CNA 11, hired 3/18/24 -lacked documentation of 6 hours of dementia training completed within 6 months of hire. d. Long standing employee- Maintenance 12, hired 12/3/21 - lacked documentation of 3 hours of dementia training within the last year. e. New hire- CNA 13, hired 5/20/24 - lacked documentation of 6 hours of dementia training	R 0120	R120 1 Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a **RN 9, CNA 10, CNA, 11 CNA 13, will be re-in serviced for 6 hours of dementia training by January 8th 2025.** b **CNA 14 and Maintenance 12 will be re in-serviced for 3 hours of dementia training by January 8th 2025** 2 Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a **All staff have the potential to be affected. Staff files will be reviewed to ensure staff received 6 hours of dementia training upon hire and 3 annually thereafter. Facility will make sure a sign in sheet accompanied each in-service and that the instructor, instructor's title,**	01/08/2025

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	completed within 6 months of hire. f. Long standing employee- CNA 14, hired 9/13/20 - lacked documentation of 3 hours of dementia training within the last year. Three of three dementia inservice training records reviewed lacked required documentation as follows: a. "Behaviors Associated With Dementia" lacked: 1. The time, date, and location. 2. The name of the instructor. 3. The title of the instructor. 4. The program content of inservice. 5. Employee's acknowledged attendance by written signature. b. "I Love Fall Prevention" lacked: 1. The time, date, and location. 2. The name of the instructor. 3. The title of the instructor. 4. The program content of inservice. 5. Employee's acknowledged attendance by written signature. c. "Communication, Feelings, and Personal Care for a Dementia Patient" lacked: 1. The time, date, and location. 2. The name of the instructor. 3. The title of the instructor. 4. The program content of inservice. 5. Employee's acknowledged attendance by written signature. During an interview on 11/22/25 at 2:15 p.m., the DON indicated she had reviewed the facility policy and realized the facility had not been documenting inservice/training records in the correct manner. The facility did not have a		**names of participants, program content of the in-service and employee signature are all listed.** 3 Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. **a All staff that provide in-service education will be in-serviced on importance of sign in sheet and what is to be included on sign-in sheet to ensure the regulation is met. Facility policy on in-service education will be reviewed at the training as well.** 4 Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a **Executive Director or designee will audit employee in-service record's twice monthly for 6 months to ensure records are being maintained appropriately.**	

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	method to report the number of hours completed during dementia training. An untitled, undated, facility policy related to inservice training, provided by the DON on 11/22/24 at 2:17 p.m., indicated the following: "...In-service records shall be maintained and shall indicate the following date, starting and ending time, location, name and title of instructor, the names of the participants, the program content/short description of content. The employee will acknowledge attendance by written signature..."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were signed by residents or their representatives for 2 of 7 residents reviewed for signed service plans (Residents 13 and 2). Findings include: 1. Resident 13's clinical record was reviewed on 11/22/24 at 11:27 a.m. Current diagnoses included dementia, hypertension, diabetes mellitus, and macular degeneration. The resident had a most current service plan dated 6/20/24 (five months prior). The service plan was not signed by the resident or their representative. The service plan indicated the family verbally agreed to the service plan. The record lacked documentation of an effort made to acquire the family member's signature. 2. Resident 2's clinical record was reviewed 11/22/24 at 11:35 a.m. Current diagnoses included	R 0217	R217 1 Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a **Service Plans will be reviewed and signed by families for Residents 13 and 2 by January 8th** 2 Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. a **All resident service plans were reviewed for a signature. For those service plans found to not have a signature, they will be reviewed with the**	01/08/2025

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dementia, diabetes mellitus, and psychosis. The resident had a most current service plan dated 10/24/24. The service plan was not signed by the resident or their representative. The service plan indicated the family verbally agreed to the service plan (29 days prior). The record lacked documentation of an effort made to acquire the family member's signature. During an interview on 11/22/24 at 11:50 a.m., the DON indicated the facility did not have family members sign service plans at a later date, when they had attended the service plan meeting via phone. The facility did not mail the service plan to acquire a signature nor have a copy of the service plan available for the family to sign during their next in person visit. The facility did not realize a signature was necessary. A current, undated, policy titled "Initial Service Plans," provided by the DON on 11/22/24 at 2:11 p.m., indicated: "...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...."		**responsible party and signed by January 8th.** 3 Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. a **Facility policy was reviewed and Director of Nursing will ensure Service Plans are signed by the responsible party within 15 days of service plan meeting if over the phone. If meeting was in person, service plan will be signed at the meeting.** 4 Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a **Director of Nursing or designee will audit service plans 2x a month for 2 months and then monthly thereafter for a total of 6 months to ensure service plans have a written signature.**	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on observation, interview, and record review, the facility failed to ensure insulin was administered by qualified personnel 1 of 1 resident reviewed for insulin administration (Resident 13).	R 0241	R241 1 Describe what the facility did to correct the deficient practice for each client cited in the	01/08/2025

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. Resident 13's clinical record was reviewed on 11/22/24 at 11:27 a.m. Current diagnoses included dementia, hypertension, diabetes mellitus, and macular degeneration. The resident had current physician's orders for the following: a. Humalog KwikPen subcutaneous solution pen injector 100 unit/ML (insulin Lispro) inject 14 units subcutaneous before meals. Inject 14 units - If the blood sugar was greater than 150. Then add corrected scale. If blood sugar was less than 100 then give 10 units. This order originated 6/13/2023 This order originated 6/13/24. b. Humalog KwikPen subcutaneous solution pen injector 100 unit/ML (insulin Lispro) inject as per sliding scale: if 150-199 = 2 units, 200-249 = 4 units, 250-299 = 6 units, 300-349 = 8 units subcutaneous before meals. This order originated 6/13/23. c. Lantus SoloStar subcutaneous solution pen-injector 100 unit/ML- inject 30 units subcutaneous every morning- supervised self-administration. This order originated 6/28/23. d. Check blood sugar 4 times daily. The resident had a 11/1/24, "Assessment for Self-Administration of Medication", which indicated the resident could identify his medication, could take the proper dosage, the resident knew why medications were taken, and could safely self-administer medications. Review of the resident's medication		deficiency. a **Resident 13's Self administration assessment was redone and resident was determined unable to administer insulin. Insulin is only being administered by licensed or certified personnel.** 2 Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. **a All resident records were reviewed and determined No other resident self-administers in the facility.** 3 Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a **QMA's and nurses will be in serviced on the facility self-administration policy. Upon admission residents will be evaluated if they wish to self-administer their own medication. If a resident is unable to self-administer injectable medications, then only Licensed personnel will administer injectable medications.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administration record for October 2024 (10/1/24 to 10/22/24) indicated the resident self administered insulin on the following dates and times: 10/1/24- 8:00 a.m., 12:00 p.m., 5:00 p.m.-QMA 2 documented the self administration. 10/7/24- 8:00 a.m., 12:00 p.m., 5:00 p.m.- QMA 2 documented the self administration. 10/9/24- 8:00 a.m., 12:00 p.m., 5:00 p.m.-QMA 2 documented the self administration. 10/10/24- 8:00 a.m., 12:00 p.m., 5:00 p.m.- QMA 2 documented the self administration. 10/12/24- 8:00 a.m., 12:00 p.m., 5:00 p.m. -QMA 3 documented the self administration. 10/13/24-8:00 a.m., 12:00 p.m., 5:00 p.m. - QMA 3 documented the self administration. 10/14/24- 5:00 p.m. - QMA 2 documented the self administration. 10/16/24-8:00 a.m., 12:00 p.m.- QMA 2 documented the self administration. 10/18/24-8:00 a.m., 12:00 p.m., 5:00 p.m. - QMA 3 documented the self administration. 10/19/24-8:00 a.m., 12:00 p.m., 5:00 p.m. - QMA 2 documented the self administration. 10/20/24 -8:00 a.m., 12:00 p.m., 5:00 p.m. -QMA 2 documented the self administration. 10/21/24 - 8:00 a.m., 12:00 p.m., 5:00 p.m. - QMA 3 documented the self administration. 10/22/24 - 8:00 a.m., 12:00 p.m., 5:00 p.m. - QMA 3 documented the self administration. During an interview on 11/22/24 at 11:31 a.m., Resident 13 indicated he did not know if he gave himself insulin injections. He did not know where his insulin was maintained. He thought he had medications in his closet and bathroom. During an observation at this time, with the permission of the resident, the resident's closet and bathroom contained no medications or medication lock boxes.		4 Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a **Director of Nursing or designee will audit Medication Administration records and med pass times 1x weekly 2 months and then monthly thereafter for a total of 6 months to ensure only licensed personnel are administering injectable medications.**	

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 11/22/24 at 11:35 a.m., QMA 4, who was administering medication on Resident 13's unit, indicated she believed Resident 13 self administered his insulin at times. She believed all of his insulin was kept in the medication room or medication storage. During an interview on 11/22/24 at 11:50 a.m., the DON indicated two QMAs in the facility (QMA 2 and 3) had completed their state required insulin administration training for QMAs and were waiting to take the state required test for QMAs to administer insulin. When these two QMAs were on duty, Resident 13 self-administered his own insulin. The resident was not able to complete his own blood sugar testing, calculate the amount of sliding scale coverage needed, nor was he able to turn the insulin pen to the correct insulin amount. The QMA would complete the blood sugar check, review the scale for sliding scale insulin coverage, add the additional needed coverage to the base dose, or determine no sliding scale coverage was required. The QMA would turn the insulin pen to the dosage the QMA had calculated was required, then the QMA gave the insulin pen to the resident for him to self administer his medication. The DON did not realize the act of calculating the sliding scale amount and turning the insulin to the required dosage would be considered as part of the actual medication administration process. A current, undated, facility policy titled, "Supervision of Self-Administered Medication", provided by the DON on 11/22/24 at 3:13 p.m., indicated the following: " ... Supervision of self-administered medication any unlicensed personnel shall be under the direction of a licensed health care professional. ...2. Confirming			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that residents have obtained and are taking the dosage as prescribed;... Residents assessed to need medication monitoring will have their medication locked in a medication box that will remain in the residents apartment at all times. Care staff may not touch the medication itself. in addition, care staff may not monitor pourable medications, medication requiring injections or perform nursing care...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on observation, interview, and record review, the facility failed to adopt and implement a tuberculosis infection control program for 2 of 5 residents reviewed for infection control. (Residents 3 and 34) Findings include: 1. A clinical record review for Resident 3 was performed on 11/22/24 at 9:43 a.m. Diagnoses included, but were not limited to, hypertension, mixed hyperlipidemia, depression, mixed dementia, and dysphagia. The clinical record indicated Resident 3 was admitted on 9/25/23. A Step 1 Mantoux tuberculin skin test (TST) was performed on 9/25/23 and results were read on 9/27/23. The results were negative. A Step 2 TST was performed on 10/16/23 and results were read on 10/18/23. The results were negative. No subsequent annual TB tests or risk assessments were performed after the initial tests at admission.	R 0407	R407 1 Describe what the facility did to correct the deficient practice for each client cited in the deficiency. a **A TB Risk assessment will be completed on Resident and 3 and 34 by January 8th 2025.** 2 Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. **a All residents have the potential to be affected. Each resident's clinical record will be reviewed for a TB risk assessment. If one is not completed, one will be completed by January 8th 2024.** 3 Describe the steps or systemic changes the facility has	01/08/2025

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. A clinical record review for Resident 34 was performed on 11/21/24 at 2:42 p.m. Diagnoses included, but were not limited to, dementia, osteoarthritis, and GERD (gastroesophageal reflux disease). The clinical record indicated Resident 34 was admitted on 4/3/23. A Step 1 TST was performed on 4/3/23 and read on 4/5/23. The results were negative. A Step 2 TST was performed on 4/17/23 and not read until 5/1/23. No subsequent annual TB tests or risk assessments were performed after the initial tests at admission. A document from The Centers for Disease Control (CDC) website at https://www.cdc.gov/tb/publications/factsheets/testing/Tuberculin_Skin_Testing_Information_for_Health_Care_Providers.pdf, retrieved on 11/25/24 at 4:11 p.m., indicated the following: "The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TST results. A patient who does not return within 72 hours will need to be rescheduled for another skin test." During an interview with the Director of Nursing (DON) on 11/22/24 at 1:54 p.m., she indicated the facility did perform annual TB risk assessments. She was not aware yearly assessments were required for residents and could not provide any TB information for residents other than the initial Step 1 and Step 2 TST's. An Infection Control Policy and Procedure, provided by the DON on 11/21/24 at 10:34 a.m., did not address a tuberculosis specific policy and procedure.		made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a **Staff will be in-serviced on the updated infection control program including TB risk assessments.** 4 Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a **Director of Nursing or designee will audit resident records 4x's a month for 2 months and then monthly thereafter for a total of 6 months to ensure each resident has a TB test upon admission and a TB risk assessment annually thereafter.**	

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	11/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE