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	11/07/2024

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 the Investigation of Complaints IN00446763 and IN00446801. Complaint IN00446763 - No deficiencies related to the allegations are cited. Complaint IN00446801 - State deficiencies related to the allegations are cited at R0052. Survey date: November 7, 2024 Facility number: 014463 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 15, 2024.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, record review, and interview, the facility failed to prevent physical and verbal abuse of a cognitively impaired resident by a facility staff member for 1 of 4 residents reviewed for abuse. (Resident D) Findings include: Resident D's clinical record was reviewed on 11/7/24 at 3:42 p.m. Diagnoses included dementia, congestive heart failure, and history of heart attack. The resident had been admitted to the secured memory care facility.	R 0052	1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency. ·Resident was removed from area with staff member who was being physically and verbally abusive. Staff Member was then removed from unit and after investigation was terminated for abuse. 2.Describe how the facility reviewed all clients in the facility that could be affected by the same	01/01/2025

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

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	11/07/2024

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
	Resident D's current service plan, dated 8/21/24, indicated she had severe cognitive impairment and required no assistance with walking, eating or transferring. The resident required minimal assistance with toileting and personal hygiene. A nursing progress note, dated 11/6/24, indicated Resident D was in the hallway, holding on to a handrail. The resident had not wanted to go back to the dining room with a staff member. Another resident's family member witnessed a staff member pull on the resident's arms "too roughly" to get her to let go of the handrail. The resident eventually sat in a chair. The DON assessed the resident, with no complaints of pain at the time. A security video, dated 11/6/24, was reviewed on 11/7/24, with the Administrator. The video showed CNA 3 walking with Resident D who was using her walker for ambulation. Resident D grabbed for the side rail with her right hand. CNA 3 grabbed the resident's right wrist and jerked it away towards the walker. Resident D looked upset and forcefully grabbed the railing with both hands. CNA 3 was observed grabbing the resident's left arm, forcefully pulling on it. CNA 3 grabbed the resident's right hand and pulled her away from the wall. Visitor 9 (another resident's family member) was observed stepping into the doorway of a room next to where Resident D was holding the handrail. CNA 3 turned towards the visitor and let go of the resident and walked away. CNA 2, who had been observed speaking to CNA 3 throughout the video, approached the resident and went with CNA 2 using her walker. The video lacked audio. During an interview on 11/7/24 at 11:20 a.m., Visitor 9 indicated she was visiting her family		deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. ·The Facility reviewed all employee files to ensure abuse prevention training had been completed. All residents had the potential to be affected. Residents and Family members will be interviewed by January 1st to ensure abuse didn't occur with other residents. 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 re in-serviced by the administrator and director of nursing on Abuse Prevention and Reporting as well as the facility policy related to abuse prevention and reporting. Staff will continue to receive training on abuse at time of hire and yearly thereafter. 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 Administrator or designee will audit employee files for in-service education monthly for 3 months, then quarterly 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	11/07/2024

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
	member when she heard another resident in the hallway "whimpering" stop it, stop it. Visitor 9 walked out of the room and observed CNA 3 holding Resident D by the wrist and yanking on her other arm to remove it from the railing. She heard CNA 3 yell at another resident, "You can't remember day by day....you are so old?" Visitor 9 observed CNA 3 turn back to Resident D and began yanking her by the arm again. Visitor 9 indicated she made her presence known and CNA 3 stopped what she was doing and walked away. There was another staff member standing close by who had spoken up when she noticed what was occurring. Visitor 9 indicated she called the DON at that time and reported what had occurred. During a phone interview on 11/7/24 at 2:54 p.m., CNA 2 indicated she was present during the incident. Resident D was due to be toileted. CNA 2 had tried to get the resident in the spa room to use the bathroom. The resident became agitated and CNA 2 escorted the resident out of the spa room. CNA 3 then attempted to take Resident D to the bathroom in her room, and the resident refused and grabbed the handrail. CNA 3 became upset and called Resident D a "old, fat,ugly lady" and asked "why don't old people listen." CNA 3 was pulling on the resident's arms to get them off the rail. The resident was continually yelling, "help me, help me." CNA 2 requested CNA 3 to walk away. CNA 3 continued, until she noticed a resident's family member watching her. At that time she walked away. CNA 2 indicated she approached the resident and she was able to redirect her to walk and use her walker. A current, undated and untitled facility policy was provided by the Administrator on 11/7/24 at 3:40 p.m., who indicated it was the facility's abuse policy. The document indicated the following:		to ensure all new staff are receiving abuse training upon hire and all staff are receiving yearly 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	11/07/2024

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
	"...Abuse Prohibition: ...Each resident shall have the right to be free from mental, emotional, social and physical abuse, neglect and exploitation. Lincolnshire Place staff and management will conduct themselves in a way that promotes the health, happiness, safety and general well being of the residents...." This citation relates to Complaint IN00446801.			