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	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE PLACE - FORT WAYNE	11911 DIEBOLD ROAD FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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. This visit included the Investigation of Complaint IN00362793. Complaint IN00362793 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 29, 30 and October 1, 2021 Facility number: 013687 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 4, 2021	R 0000		
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; (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			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE PLACE - FORT WAYNE	11911 DIEBOLD ROAD FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	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 maintain a signed and dated service plan by the resident for 1 of 7 residents reviewed. (Resident 7) Findings included: The record for Resident 2 was reviewed on 9/27/21 at 11:35 AM, diagnosis included anxiety disorder and other symptoms and signs involving cognitive functions and awareness. The record indicated Resident 2 had a Power of Attorney (POA). A service plan with an effective date of 6/3/20 was reviewed. There was no signature of the POA observed on the document. No other service plan was observed in Resident 2's chart. During an interview, the Director of Nursing (DON) on 10/1/21 at 10:31 AM, indicated normally when she would complete an assessment, she would go over the service plan. The DON also indicated she would leave the service plan with the nurses and when the families came in she would have them sign the plan. The DON indicated she did not have any documentation to state that she spoke with the	R 0217	**R217** -Resident service plan found to be in noncompliance was identified. Service plan will be updated and given to POA for review and signature. -Director of Nursing will review all service plans of current residents and ensure all are in compliance. Any identified to be in noncompliance will be corrected and noted to the QA committee. -The Director of nursing, all nurses and QMAs will be in-serviced on the correct policy on service plans. Director of Nursing will be made responsible to ensure policy is followed and all service plans are signed by the POA. -The QA committee will ensure that the identified noncompliance has been corrected. Also, the Director of Nursing will be responsible to review all service plans quarterly to ensure	10/29/2021

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	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE PLACE - FORT WAYNE	11911 DIEBOLD ROAD FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	family about the service plan. A facility policy, Initial Service Plan, was provided by the DON on 10/1/21 at 10:32 AM. The policy 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...."		compliance with policy. These reviews will be sent to the QA committee to ensure compliance and identify/correct any problems that arise. -These changes will be completed by 10/29/2021. We ask based on these corrections that we receive a paper compliance for this tag.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review, observation and interview the facility failed to follow physician orders for 3 of 7 residents reviewed for physician orders. (Resident 1, Resident 14 and Resident 21) Findings include: 1. A record review was completed for Resident 1 on 9/30/21 at 9:15 A.M. Diagnosis included, but were not limited to, dementia and hypothyroidism. An order for levothyroxine 50mcg, entered 2/12/20, indicated to give early morning (6:30AM to 8AM) for hypothyroidism. During an observation on 9/29/21 at 10:09 AM, Employee 2 gave levothyroxine to Resident 1. The Director of Nursing (DON) was interviewed on 9/30/21 at 9:12 A.M. The DON indicated they	R 0240	**R240** -The three physician orders were identified to be in noncompliance. All three orders were clarified and all nurses and QMAs will be in-serviced on the correct procedure regarding these orders. -Director of Nursing will review the physician orders for all our residents to ensure there are no discrepancies. Also, the Director of nursing will do random Quality Assurance checks (at least one per shift each week for 6 months) to ensure physician orders are being correctly followed. All QA checks will be sent to the QA committee for review. -All nurses and QMAs will be retrained in the Medication Administration and physician orders policy. Training will be	10/29/2021

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	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE PLACE - FORT WAYNE	11911 DIEBOLD ROAD FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	have block med pass times; to help ensure nursing has time to offer medication several times. DON indicated the medications should be given one hour prior or one after following administration time. 2. A record review was completed for Resident 14 on 9/30/21 at 9:20 A.M. Diagnosis included, but not limited to, hypothyroidism, Alzheimer's dmentia, and anxiety. An order for levothyroxine 175mcg entered 9/3/21 indicated to give early morning (6:30AM to 8 AM) for low thyroid. During an observation, Staff 2 administered levothyroxine at 9:52 AM on 9/29/21 to Resident 14 3. A record review for Resident 21 was completed on 9/29/21 at 1 PM. Diagnosis included, but not limited to, type 2 diabetes melllutus. An order, dated 4/13/21, indicated to give basaglar kwikpen solution pen injector 100 unit/ml (insulin) to inject 25 units subcutaneously in the evening for type 2 diabetes mellitus. The Medication Administration Record (MAR) indicated Resident 21 did not receive medication as ordered on 7/19/21, 7/28/21, and 7/29/21. An order, dated 5/7/2021, novolog solution 100 unit/ml (insulin) to inject before meals (7:30 AM; 11 AM; 4 PM) per sliding scale: if 151-200 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; if over 400 call Medical Director for type 2 diabetes		documented and given to the QA committee. -The Quality Assurance committee will review the trainings to ensure compliance. Also, the committee will review the random checks done by the Director of Nursing for 6 months to ensure compliance. All identified issues will be noted by the QA committee and corrected based on the noncompliance. -These changes will be completed by 10/29/2021. We ask based on these corrections that we receive a paper compliance for this tag.	

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	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE PLACE - FORT WAYNE	11911 DIEBOLD ROAD FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	mellitus. The MAR indicated the order was not followed as ordered on: 7/8/21, 7/16/21, 7/20/21, 7/24/21 at 11 AM; 7/28/21 at 4 PM; 8/9/21, 8/30/21 and 8/31/21 at 11 AM; 9/1/21, 9/10/21, 9/16/21 9/19/21 and 9/24/21 at 11 AM. The DON was interviewed on 9/29/21 at 9:19 AM. The DON indicated the staff should have given Resident 21's medication as ordered and documented amount given per sliding scale. A policy, titled "Medication Administration" was provided by the DON on 9/30/2021 at 9:33A.M. The policy indicated the person who administrated the medication should follow physician orders.			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interviews the facility failed to properly label 1 of 2 resident's medication (Resident 11).	R 0301	**R301** -The medication for resident 11 that was incorrectly labeled was identified. The medication	10/29/2021

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	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE PLACE - FORT WAYNE	11911 DIEBOLD ROAD FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: A record review was completed for Resident 11 on 9/30/21 at 8:15 A.M. Diagnosis included, but were not limited to, altered mental status, cognitive impairment and diabetes. An order on 9/25/21 indicated to give Novolog Flexpen for Diabetes; inject as per sliding scale: 160-200 1 unit: 201-240=2units; 241-280=3units; 281-320=4units; 321-360 5units; 361+=6units subcutaneously three times a day. An observation on 9/29/21 at 12:43PM noted Novolog Flexpen in the top drawer of the medication cart labeled with Resident 11's name. The pen was used and was observed to have 15units available. RN 2 was interviewed during this time. RN 2 indicated the pen should have been labeled with an open date as well as prescriber name. The Director of Nursing (DON) was interviewed on 9/30/21 at 9:21AM. She indicated all medications are to be labled with resident name, prescribing physician, date opened and expiration date. A policy titled, "Labeling of Medication" received from DON on 9/30/21 at 9:33AM indicated medications were to be labeled with resident's full name, physician's name, prescription number, name and strength of drug, directions for use, date of issue and expiration date and name and address of the pharmacy that filled prescription.		identified as incorrectly labeled was corrected to ensure compliance. -The other medications for resident 11 were reviewed to ensure they were correctly labeled. All other residents will have their medications reviewed by the Director of nursing to ensure they are correctly labeled. Any discrepancies identified will be sent to the QA Committee for review. -All nurses and QMAs will be retrained on the Labeling of Medication policy. Theses trainings will be sent to the QA Committee for review. We will also be using our pharmacy consultant to do medication checks every other month to ensure compliance. The Director of Nursing will conduct med cart audits at least once a month for one year to ensure all medications are labeled appropriately. -Quality Assurance committee will review the Director of Nursing's monthly checks to ensure compliance. All identified errors will be documented and staff will be retrained. QA committee will review staff trainings to ensure all appropriate staff have been trained on labeling policy. -These changes will be completed by 10/29/2021. We ask based on these corrections that we receive a paper compliance for this tag.	