STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: October 18 & 19, 2021 Facility number: 014463 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 25, 2021.	R 0000		
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (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	R 0092	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2) How the facility will identify other residents	11/05/2021

	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 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 interview and record review, the facility failed to ensure fire drills were conducted on day shift during the first quarter of 2021, on all shifts during the second quarter of 2021, and on night shift during the third quarter of 2021. Findings include: Review of the Fire Drill Logs provided by the Administrator on 10/18/21 at 12:05 p.m., indicated the following: a. The log lacked documentation of a fire drill being conducted on first shift		having the potential to be affected by the same deficient practice and what corrective action will be taken; No residents affected. All staff in serviced on fire drills. 3) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The ED/designee will conduct fire drills once monthly on all 3 shifts. 4) 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; and Facility will review Fire Drill log weekly for 1 month, Bi-weekly for 1 months, and 1 time monthly for 3 months. 5) By what date the systemic changes will be completed. 11/5/21	

	during the first quarter of 2021. b. The log lacked documentation of any fire drills being conducted during the second quarter of 2021. c. The log lacked documentation of a fire drill being conducted on third shift during the third quarter of 2021. During an interview on 10/18/21 at 11:07 a.m., the Administrator indicated the record was correct that the fire drills had not been completed quarterly on each shift. A current facility policy, undated, titled, "Chapter 10: Community Safety," provided by the Administrator on 10/18/21 at 12:03 p.m., included, but was not limited to: "...Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions (times)." Based on interview and record review, the facility failed to ensure fire drills were conducted on day shift during the first quarter of 2021, on all shifts during the second quarter of 2021, and on night shift during the third quarter of 2021. Findings include:		Please review for Paper compliance.	

	Review of the Fire Drill Logs provided by the Administrator on 10/18/21 at 12:05 p.m., indicated the following: a. The log lacked documentation of a fire drill being conducted on first shift during the first quarter of 2021. b. The log lacked documentation of any fire drills being conducted during the second quarter of 2021. c. The log lacked documentation of a fire drill being conducted on third shift during the third quarter of 2021. During an interview on 10/18/21 at 11:07 a.m., the Administrator indicated the record was correct that the fire drills had not been completed quarterly on each shift. A current facility policy, undated, titled, "Chapter 10: Community Safety," provided by the Administrator on 10/18/21 at 12:03 p.m., included, but was not limited to: "...Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions (times)."			
R 0119	Personnel - Noncompliance	R 0119	1)	11/05/2021

	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; No residents affected. 3) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Facility reviewed all current staff's files for job specific orientations. Any staff missing job specific orientations completed new ones. 4) 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; and ED or designee will implement a check off	

	(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to provide job specific orientation to employees hired to work at the facility for 4 of 5 new employee files reviewed. Findings include: During a review of employee records information on 10/18/21 at 2:25 p.m., four of five employees lacked documentation of job specific orientation. During an interview on 10/19/21 at 8:48 a.m., the Administrator indicated the documentation of specific job orientation was not completed for the employees reviewed. She indicated this should be completed for all employees upon hire. A facility policy, undated, titled, "Employee File," provided by the Administrator on 10/19/21 at 8:57 a.m., included, but was not limited to, the following: "...The personnel records for all		list to monitor completion of job specific orientation on all new hires, 5 times a week for 1 month, 1 time weekly for 1 month, and 1 time monthly for 3 months. 5) By what date the systemic changes will be completed. 11/5/21 Please review for Paper compliance.	

	employees shall include the following:...10. Documentation of training to specific job skills... Job Specific Orientation. Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Documentation of the orientation in the employee's personnel record by the person supervising the orientation." Based on record review and interview, the facility failed to provide job specific orientation to employees hired to work at the facility for 4 of 5 new employee files reviewed. Findings include: During a review of employee records information on 10/18/21 at 2:25 p.m., four of five employees lacked documentation of job specific orientation. During an interview on 10/19/21 at 8:48 a.m., the Administrator indicated the documentation of specific job orientation was not completed for the employees reviewed. She indicated this should be completed for all employees upon hire. A facility policy, undated, titled, "Employee File," provided by the Administrator on 10/19/21 at			

	8:57 a.m., included, but was not limited to, the following: "...The personnel records for all employees shall include the following:...10. Documentation of training to specific job skills... Job Specific Orientation. Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Documentation of the orientation in the employee's personnel record by the person supervising the orientation."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (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 ensure sanitation and safe food handling practices were maintained in the 100 unit refrigerator and microwave. Findings include: During an initial tour of the 100	R 0273	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; No residents were affected. All pre-dished, uncovered items were disposed of and were not served. All other items uncovered or undated were covered and	11/05/2021

	unit on 10/18/21 at 9:57 a.m., two pudding cups were observed on the top shelf of the refrigerator, uncovered and undated. Four small bowls with baked apples were observed on the top shelf of the refrigerator without a date. Three pitchers containing orange, yellow and brown liquids were observed without dates or identifying labels. A square, covered container with applesauce was observed in the refrigerator without a date, and another container of applesauce was observed on the counter without a date. The microwave oven was observed to have two plates of uncovered food sitting in the microwave. During an interview on 10/18/21 at 10:02 a.m., CNA 3 indicated the two plates in the microwave held French toast casserole and bacon. CNA 3 indicated they were put there in case a resident became hungry before lunch and had been in the microwave for approximately 30 minutes and were not covered. During an interview on 10/18/21 at 11:02 a.m., the Administrator indicated all stored food should be covered and dated. Food should not be stored in the microwave oven. A current facility policy, undated, titled, "Food Storage," provided by the Administrator on		dated appropriately as stated in the policy “Food Storage”. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All staff in serviced on “Food Storage” policy. DNS/designee will continue this training with all new staff as part of the orientation process. 4) 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; and DNS/designee will monitor proper storage of perishable foods daily. DNS/designee will monitor pod refrigerators and microwaves 3 times per week for 1 month, 1 time weekly for 1 month, then 2 times a month for 3 months to ensure all food is properly stored, covered, labeled, and dated per policy. Any issues identified will be addressed immediately. Findings will be	

	10/18/21 at 11:05 a.m., included, but was not limited to, the following: "...Prepared foods or foods not stored in their original container must be covered, labeled and dated (date prepared or dated opened)." Based on observation, interview, and record review, the facility failed to ensure sanitation and safe food handling practices were maintained in the 100 unit refrigerator and microwave. Findings include: During an initial tour of the 100 unit on 10/18/21 at 9:57 a.m., two pudding cups were observed on the top shelf of the refrigerator, uncovered and undated. Four small bowls with baked apples were observed on the top shelf of the refrigerator without a date. Three pitchers containing orange, yellow and brown liquids were observed without dates or identifying labels. A square, covered container with applesauce was observed in the refrigerator without a date, and another container of applesauce was observed on the counter without a date. The microwave oven was observed to have two plates of uncovered food sitting in the microwave. During an interview on 10/18/21		reported to the ED for follow up. 5) By what date the systemic changes will be completed. 11/5/21 Please review for Paper compliance.	

	at 10:02 a.m., CNA 3 indicated the two plates in the microwave held French toast casserole and bacon. CNA 3 indicated they were put there in case a resident became hungry before lunch and had been in the microwave for approximately 30 minutes and were not covered. During an interview on 10/18/21 at 11:02 a.m., the Administrator indicated all stored food should be covered and dated. Food should not be stored in the microwave oven. A current facility policy, undated, titled, "Food Storage," provided by the Administrator on 10/18/21 at 11:05 a.m., included, but was not limited to, the following: "...Prepared foods or foods not stored in their original container must be covered, labeled and dated (date prepared or dated opened)."			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection	R 0407	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2) How the facility will identify other residents	11/05/2021

	prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. A. Based on observation and interview, the facility failed to properly utilize infection prevention strategies when care was provided within six feet of residents, during a COVID-19 pandemic, for 2 of 3 residents reviewed for infection prevention and control. (Residents 22 and 23) Findings include: During an initial tour of the 100 unit on 10/18/21 at 9:56 a.m., staff were observed wearing surgical masks with no eye protection and were observed providing care to residents within six feet of residents. During an observation on 10/18/21 at 11:00 a.m., the Activity Director (AD) held an activity in which a balloon was hit back and forth with a tennis racket. It was held in the common area with 10 residents seated in chairs and arranged in a large circle. Resident 22 was seated in a wheelchair rather than a chair. During the activity, the AD lacked eye protection		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. 3) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The ED/designee in serviced all staff on proper us of face shields while in the community. 4) 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; and The DNS/designee will monitor face shield compliance 5 times a week for 1 month, 2 times a week for 1 month, 2 times a month for 1 month, and then monthly for 2 months. Any issues identified will be addressed immediately with the individual associate to involve education and/or counseling by the ED and/or the DNS. Issues will also be	

	and assisted Resident 22 with the activity while she stood closer than three feet. During an interview on 10/19/21 at 11:03 a.m., the AD indicated she did not have eye protection on during the balloon activity on 10/18/21 at 11:00 a.m. when she assisted Resident 22 because she was not aware that eye protection should have been worn. During a dining room observation on 10/18/21 at 12:05 p.m., staff were observed wearing surgical masks and gloves without eye protection and provided lunch trays to the residents within six feet. During an observation on 10/18/21 at 12:08 p.m., Certified Nurse's Aide (CNA) 2 sat down beside Resident 23 in the dining room, closer than three feet distance, and assisted Resident 23 with her meal. CNA 2 wore gloves and a surgical mask but lacked any eye protection. During an observation, along with the DON, on 10/18/21 at 12:22 p.m., the DON indicated CNA 2 was unvaccinated and sat next to Resident 23 and fed her within three feet of the resident. CNA 2 wore gloves and a surgical mask during the observation but lacked any eye protection. During an observation on		addressed during the weekly stand up meeting on Mondays. 5) By what date the systemic changes will be completed. 11/5/21 Please review for Paper compliance.	

10/18/21 at 12:34 p.m., CNA 2 exited the dining room table after she assisted Resident 23, within three feet of the resident for 26 minutes, and without any eye protection.

During an interview on 10/18/21 at 11:33 a.m., the Administrator indicated unvaccinated staff were required to wear a face shield and surgical mask when care was provided in the residents' rooms. She indicated vaccinated staff were required to only wear a surgical mask when care was provided in the residents' rooms.

During an interview on 10/18/21 at 2:20 p.m., the Administrator indicated the facility followed Center for Disease Control (CDC) guidance regarding personal protective equipment (PPE) required for staff, when care was provided within 6 feet of the residents. A request was made for a facility policy that indicated the staff required PPE, in different zones, when care was provided within six feet. The Administrator indicated the facility did not have a specific policy for the requested topic.

During an interview on 10/18/21 at 3:30 p.m., the Administrator indicated she reviewed the updated guidance from the Indiana Department of Health (IDOH) dated 9/28/21 and found that all staff should have worn

eye protection when resident care was provided within six feet of the resident. She indicated the facility did not follow the updated guidance she received in the Long Term Care Newsletter on 10/7/21, regarding staff required eye protection with resident care when within six feet of the resident.

During an interview on 10/19/21 at 8:28 a.m., the Administrator indicated the COVID-19 Tracker showed the facility's county was in high community transmission.

A current policy, undated, titled, "Lincolnshire Place Covid-19 Policy," provided by the Administrator on 10/18/21 at 2:38 p.m., included, but was not limited to, the following:

"1. It is the policy of Lincolnshire Place to follow the most up to date guidance from IDOH [Indiana Department of Health]. This includes any infection control, visitation requirements, SOP [Standard Operating Procedure], and new Covid-19 clinical guidance.

2. This guidance will be updated as IDOH sends out alerts.

3. New guidance will be implemented by the required date set forth by IDOH."

A. Based on observation and interview, the facility failed to

properly utilize infection prevention strategies when care was provided within six feet of residents, during a COVID-19 pandemic, for 2 of 3 residents reviewed for infection prevention and control. (Residents 22 and 23)

Findings include:

During an initial tour of the 100 unit on 10/18/21 at 9:56 a.m., staff were observed wearing surgical masks with no eye protection and were observed providing care to residents within six feet of residents.

During an observation on 10/18/21 at 11:00 a.m., the Activity Director (AD) held an activity in which a balloon was hit back and forth with a tennis racket. It was held in the common area with 10 residents seated in chairs and arranged in a large circle. Resident 22 was seated in a wheelchair rather than a chair. During the activity, the AD lacked eye protection and assisted Resident 22 with the activity while she stood closer than three feet.

During an interview on 10/19/21 at 11:03 a.m., the AD indicated she did not have eye protection on during the balloon activity on 10/18/21 at 11:00 a.m. when she assisted Resident 22 because she was not aware that eye protection should have

been worn.

During a dining room observation on 10/18/21 at 12:05 p.m., staff were observed wearing surgical masks and gloves without eye protection and provided lunch trays to the residents within six feet.

During an observation on 10/18/21 at 12:08 p.m., Certified Nurse's Aide (CNA) 2 sat down beside Resident 23 in the dining room, closer than three feet distance, and assisted Resident 23 with her meal. CNA 2 wore gloves and a surgical mask but lacked any eye protection.

During an observation, along with the DON, on 10/18/21 at 12:22 p.m., the DON indicated CNA 2 was unvaccinated and sat next to Resident 23 and fed her within three feet of the resident. CNA 2 wore gloves and a surgical mask during the observation but lacked any eye protection.

During an observation on 10/18/21 at 12:34 p.m., CNA 2 exited the dining room table after she assisted Resident 23, within three feet of the resident for 26 minutes, and without any eye protection.

During an interview on 10/18/21 at 11:33 a.m., the Administrator indicated unvaccinated staff were required to wear a face shield and surgical mask when

care was provided in the residents' rooms. She indicated vaccinated staff were required to only wear a surgical mask when care was provided in the residents' rooms.

During an interview on 10/18/21 at 2:20 p.m., the Administrator indicated the facility followed Center for Disease Control (CDC) guidance regarding personal protective equipment (PPE) required for staff, when care was provided within 6 feet of the residents. A request was made for a facility policy that indicated the staff required PPE, in different zones, when care was provided within six feet. The Administrator indicated the facility did not have a specific policy for the requested topic.

During an interview on 10/18/21 at 3:30 p.m., the Administrator indicated she reviewed the updated guidance from the Indiana Department of Health (IDOH) dated 9/28/21 and found that all staff should have worn eye protection when resident care was provided within six feet of the resident. She indicated the facility did not follow the updated guidance she received in the Long Term Care Newsletter on 10/7/21, regarding staff required eye protection with resident care when within six feet of the resident.

	During an interview on 10/19/21 at 8:28 a.m., the Administrator indicated the COVID-19 Tracker showed the facility's county was in high community transmission. A current policy, undated, titled, "Lincolnshire Place Covid-19 Policy," provided by the Administrator on 10/18/21 at 2:38 p.m., included, but was not limited to, the following: "1. It is the policy of Lincolnshire Place to follow the most up to date guidance from IDOH [Indiana Department of Health]. This includes any infection control, visitation requirements, SOP [Standard Operating Procedure], and new Covid-19 clinical guidance. 2. This guidance will be updated as IDOH sends out alerts. 3. New guidance will be implemented by the required date set forth by IDOH."				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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