STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/24/2025

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 the Investigation of Complaint IN00462808. Complaint IN00462808 - State Residential Findings related to the allegations are cited at R0052. Survey date: July 24, 2025 Facility number: 014463 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 31, 2025.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	Upon interview of the resident, he told the director what window he climbed out of and blocks were immediately placed in that window. All other windows were checked for the blocks and no others were found to be without blocks. Resident was assessed by RN and	07/25/2025

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure interventions were in place to protect a resident's right to be free from elopement for 1 of 3 cognitively impaired residents reviewed for elopement by failing to provide secure windows on a secured memory care unit. (Resident B) This deficient practice resulted in a cognitively impaired resident being found, unsupervised, off facility property and had the potential to affect 42 of 42 cognitively impaired residents living in the facility. Findings include: Resident B's clinical record was reviewed on 7/3/25 at 12:31 p.m. Diagnoses included severe dementia with psychotic disturbances, type 2 diabetes, chronic venous hypertension, and gastro-esophageal reflux disease. Review of a facility reportable incident dated 7/3/25 indicated Resident B had eloped from the		Q1 hour checks were implemented for 24 hours. In review of how this could impact other residents, fixing the window blocks would not allow any other residents to climb out of the window. In review for our staff, we reviewed our elopement policy and instructed on importance of visualization of residents while on their shifts. This was verbal communication with staff and a signed acknowledge sheet. The window blocks will be checked for placement on the first of every month and documented on a maintenance log.	

secured facility through a window at the end of the unit at 3:30 a.m.

During an interview on 7/24/25 at 11:47 a.m., the Administrator indicated Resident B found by the local police at a fast-food restaurant on 7/3/25. The location was approximately 4.6 miles (1 hour and 42 minutes walking per Google Maps) from the facility. The resident had been returned to the facility by the local police and placed on one-hour checks.

During an interview, on 7/24/25 at 1:47 p.m., the Administrator indicated she had observed a security video of the resident leaving the facility. The security video was not available during the survey.

During a 7/24/25 observation of the 4.6-mile distance via car, the road had few street lights for night visibility. The ground was uneven in areas and contained wooded areas. The resident would also have had to cross a major intersection of four lane highway.

During a unit tour on 7/24/25 from 11:30 a.m. to 2:00 p.m., Resident B was observed ambulating throughout the facility independently using a cane. The windows at the end of the unit had been fitted with blocks to secure restrict opening

more than 6-8 inches. The Administrator indicated the window the resident used to elope had been missed when the blocks were installed in the facility windows.

During an interview on 7/24/2025 at 12:35 p.m. QMA 1 indicated Resident B was known as an elopement risk. Staff try to keep a better eye on him. The resident did not like for staff to open the door to his room at night and threatened to throw rocks at them.

During an interview on 7/3/2025 at 12:45 p.m., CNA 2 indicated the resident was very active in activities and enjoyed sitting by the window to watch the wildlife outside. The resident did not like being disturbed at night and did not want anyone checking on him.

During the survey, the staff members who were present when the elopement occurred were unable to be interviewed. Their written statements were provided as part of the investigation.

A written statement by CNA 3 dated 7/3/2025 indicated the resident had last been seen at 11:00 p.m. on 7/2/2025. The CNA left the facility at 3:00 a.m.

A written statement by HHA 4, dated 7/3/2025, indicated the HHA left the unit at 3:00 a.m. to

assist on the other unit after getting report from CNA 3.

This citation relates to Complaint IN00462808.

Based on observation, interview, and record review, the facility failed to ensure interventions were in place to protect a resident's right to be free from elopement for 1 of 3 cognitively impaired residents reviewed for elopement by failing to provide secure windows on a secured memory care unit. (Resident B) This deficient practice resulted in a cognitively impaired resident being found, unsupervised, off facility property and had the potential to affect 42 of 42 cognitively impaired residents living in the facility.

Findings include:

Resident B's clinical record was reviewed on 7/3/25 at 12:31 p.m. Diagnoses included severe dementia with psychotic disturbances, type 2 diabetes, chronic venous hypertension, and gastro-esophageal reflux disease.

Review of a facility reportable incident dated 7/3/25 indicated Resident B had eloped from the secured facility through a window at the end of the unit at 3:30 a.m.

During an interview on 7/24/25

at 11:47 a.m., the Administrator indicated Resident B found by the local police at a fast-food restaurant on 7/3/25. The location was approximately 4.6 miles (1 hour and 42 minutes walking per Google Maps) from the facility. The resident had been returned to the facility by the local police and placed on one-hour checks.

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facility windows.

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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