PRINTED: 08/16/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN (	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
			B. WI	B. WING			2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				MORRISON RD		
MUNCIE	ESTATES SENIOR	RLIVING			E, IN 47304		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
	This visit was for th	e Investigation of Complaint	R 00	000	This plan of correction is not to	be	
	IN00434037.				interpreted as an admission of	or	
					agreement with the findings ar	nd	
	•	037- State deficiencies related			conclusions in the Statement of		
	to the allegations are	e cited at R0217.			Deficiencies dated 7/19/24. It		
					submission of our ongoing effo	orts	
	Survey date: July 19	9, 2024			to comply with regulatory		
	- III	000			requirements. We have outline		
	Facility number: 01	0886			specific actions in response to		
	D 11 11 G	54			identified issues. We remain		
	Residential Census:	54			committed to the delivery of		
	TT C . D . 1	21 1 E1 11 22 11			quality health care services an		
	accordance with 410	ntial Findings are cited in			will continue to make changes	and	
	accordance with 410	0 IAC 10.2-3.			improvements in line with that		
	Quality raview com	pleted July 26, 2024.			objective.		
	Quality Teview Colli	preted Jury 20, 2024.					
R 0217	410 IAC 16.2-5-2(	e)(1-5)					1
	Evaluation - Defici	* * * *					
Bldg. 00		pletion of an evaluation, the					
ŭ	` '	opriately trained staff					
		entify and document the					
		vided by the facility, as					
	follows:	· ·					
	(1) The services o	ffered to the individual					
	resident shall be a	ppropriate to the:					
	(A) scope;						
	<ul><li>(B) frequency;</li></ul>						
	(C) need; and						
	(D) preference;						
	of the resident.						
		ffered shall be reviewed and					
		riate and discussed by the					
		y as needs or desires					
	•	facility or the resident may					
	request a service						
	(3) The agreed up	on service plan shall be					
l					I .		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Dawn Beeman Health Facility Administrator 08/08/2024

Any defiency statement 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.

State Form Event ID: 5FTR11 Facility ID: 010886 If continuation sheet Page 1 of 9

PRINTED: 08/16/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  A BILLIDING  NAME OF PROVIDER OR SUPPLIER  MUNCIE ESTATES SENIOR LIVING  IVA JID  SUMMARY STATEMENT OF DEFICIENCIE  (RACH DEFICIENCY MUST BE PRECEDED BY PULL  TAG  REGULATORY OR SEE IDENTIFING NORMATION  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 of the services provided is needed if evaluations or the provision of residential nursing services.  (5) If administration of medications or the provision of residential nursing services.  (6) 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 observation, record review, and interventions to prevent falls for 2 of 3 residents reviewed for falls. (Resident B and Resident C)  Findings include:  1. Resident B's clinical record was reviewed on 77/19/24 at 11-01 a.m. Diagnoses included memory loss, diabetes mellitus type 2; and macular degeneration.  A care plan, dated 5/324, indicated the resident had the following fall interventions: Nonstip mat to recliner. Resident to be assisted to the hathroom every 2 hours from 7 a.m. to 9 a.m. Staff to increase observation of resident during waking hours. Call don't fall sign placed in residents view.  A Saint Louis University Mental Status (SLUMS) assessment, dated 3/5/24, indicated the resident was severely cognitively impaired.  A SLUMS assessment, dated 6/23/24, indicated the resident was severely cognitively impaired.	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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State Form Event ID: 5FTR11 Facility ID: 010886 If continuation sheet Page 2 of 9

PRINTED: 08/16/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/19/2024	
NAME OF PROVIDER OR SUPPLIER  MUNCIE ESTATES SENIOR LIVING			1601 N	ADDRESS, CITY, STATE, ZIP COD MORRISON RD IE, IN 47304	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	resident was at mode A Change of Conditional Condition	tion evaluation, dated 3/5/24, and required physical member for transfers. She ance with toileting one to six neet for July 2024 lacked initials pletion on 7/1/24, 7/2/24, 24, 7/8/24, 7/10/24, 7/11/24, 17/24, and 7/18/24 on shift one 1, 7/12/24, and 7/18/24 on shift one 1, 7/12/24, and 7/18/24 on shift one 2, 7/12/24, and 7/18/24 on shift one 3, 7/12/24, and 7/18/24, and		ongoing.  Results of care plan review will be discussed at monthly of meetings.	vs
	floor. A small area to bruised.  An Observation No indicated the resident front of her recliner raised. The resident the bathroom and endouble and the control of her bedroom front of her. Her was front of her.  An Observation No indicated the resident front of her.	te, dated 4/21/24 at 11:34 a.m., at was found on the floor in a floor of the recliner was got out of the recliner to go to anded up on the floor.  te, dated 4/29/24 at 10:00 a.m., at was observed sitting on the mouth with her legs outstretched in a floor in the floor.  te, dated 5/3/24 at 4:00 a.m., at was in the bathroom in the floor and the bed and the bathroom			

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PRINTED: 08/16/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 07/19/2024		
NAME OF PROVIDER OR SUPPLIER  MUNCIE ESTATES SENIOR LIVING				1601 N	ADDRESS, CITY, STATE, ZIP COD MORRISON RD E, IN 47304	
P	X4) ID REFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION were under the bed.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		An Observation Not indicated the resident was found it resident complained had light blue bruising. An Observation Not indicated the resident the doorway on the uncertain of what had of soreness to her risidentified.  An Observation Not indicated the resident the hallway. She included the hallway of the indicated the resident the hallway of the resident outside of her room walker was inside his observation Not indicated the resident outside of her room walker was inside his observation of the room walker was inside his observation of the resident that was nonslip. The had gotten dirty and she was uncertain it back on the recliner.  During an observation of the resident that was nonslip. The had gotten dirty and she was uncertain it back on the recliner.	te, dated 5/26/24 at 10:36 p.m., at fell in her room. The nurse heard the resident fall, and alling out for help. The lying on the floor. The lof pain to her right knee and ang to the area.  te, dated 6/10/24 at 10:55 p.m., at was found sitting upright in floor of her room. She was ad happened. She complained ght hip. No injuries were  te, dated 6/12/24 at 10:53 p.m., at was found on the floor in dicated she had lost her  te, dated 6/22/24 at 2:03 p.m., at was found on the floor in dicated she had lost her  te, dated 6/22/24 at 1:22 p.m., CNA at B fell sometimes. She had something on her couch the nonslip mat on her recliner as was removed to be washed. If the nonslip mat had been put			
		2	1			

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PRINTED: 08/16/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA C AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 19/2024
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP MORRISON RD	COD	
MUNCIE ESTATES SENIOR LIVING				E, IN 47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	PRRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	During an interview Health Aide (HHA) the facility less than what fall intervention did not know of any paper she could che She indicated Reside bathroom before an called for assistance.  During an interview 3 indicated the resident was well interventions which bathroom every 2 hononslip mat to the resident was very implemented several prevent falls.  During an observation Resident B's room I and a nonslip mat to the Interim HSD indon't fall" sign on he was unable to lot to the resident's recipion.  During an interview Administrator indicates the service plan and needed.	dent' interventions were clicked so She pointed to Resident B's included assist to the ours from 7 a.m. to 9 p.m. and ecliner.  7, on 7/19/24 at 1:52 p.m., the rices Director (HSD) indicated by confused. The facility had all different fall interventions to son, on 7/19/24 at 2:00 p.m., acked a "Call don't fall" sign of her recliner. At the same time, dicated resident had a "Call er wall in her room at one time. Incate the sign or a nonslip mat				

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PRINTED: 08/16/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING B. WING	00	COMPLE 07/19/2	ΓED
NAME OF PROVIDER OR SUPPLIER  MUNCIE ESTATES SENIOR LIVING			1601 N	ADDRESS, CITY, STATE, ZIP COD MORRISON RD E, IN 47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  FREFIX  GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	osteoporosis, conge artery disease, and	estive heart failure, coronary anxiety.				
	had the following fa	5/16/24, indicated the resident all interventions: Nonslip mat ease observation during				
		ent, dated 4/24/24, indicated verely cognitively impaired.				
		ent, dated 6/23/24, indicated verely cognitively impaired.				
	A fall risk assessme resident was at mod	ent, dated 4/24/24, indicated the derate risk for falls.				
	A fall risk assessme resident was at mod	ent, dated 6/15/24, indicated the derate risk for falls.				
	indicated the reside	tion evaluation, dated 6/15/24, nt required escort to meals, n toileting, and staff standby sefers.				
	indicating care com 7/3/24, 7/6/24, 7/7/ 7/15/24, 7/16/24, 7/ and 7/6/24, 7/10/24 two for the followin	neet for July 2024 lacked initials appletion on 7/1/24, 7/2/24, 24, 7/8/24, 7/10/24, 7/11/24, 7/17/24, and 7/18/24 on shift one 2, 7/12/24, and 7/18/24 on shift ag fall interventions: Nonslip increase observation during				
		ote, dated 4/5/24 at 10:09 p.m., nt was found sitting on the e doorway.				
		ote, dated 4/20/24 at 12:16 p.m., nt was found sitting in front of				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	nstruction 00	COM	re survey ipleted 19/2024	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP (	COD	
MUNCIE	ESTATES SENIOR	RLIVING		MORRISON RD E, IN 47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
		egs outstretched in front of her.				
	An Observation No indicated the reside assistance and was against her closet do pain to her right hip her right elbow. She emergency medical  An Observation No indicated the reside indicated the reside was able to stand ar  An Observation No indicated the reside was able to stand ar	te, dated 5/7/24 at 8:11 a.m., and had used the call light for found sitting on the floor poor. She complained of severe as She had a small skin tear on the was transported by services to the hospital te, dated 5/7/24 at 11:25 a.m., and the representative called and and the had a right hip fracture.  te, dated 6/15/24 at 11:15 a.m., and returned to the facility. She and pivot for transfers.  te, date 7/4/24 at 1:06 p.m., and reached for her walker after the in the dining room and fell				
	onto her left side. Sher left shin.	he received a small skin tear to				
	Resident C sat in he indicated she pushe	on, on 7/19/24 at 10:11 a.m., or wheelchair in her room. She d her pendant for assistance needed. The recliner lacked a				
	3 indicated the resid	y, on 7/19/24 at 1:22 p.m., CNA dent would push her button for not remember the resident at on her recliner.				
	Interim HSD indica mobile as she had p	y, on 7/19/24 at 1:52 p.m., the ted the resident was not as reviously been prior to her ed standby assistance with				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVE COMPLETED 07/19/2024	Y			
	PROVIDER OR SUPPLIER		1601 N	STREET ADDRESS, CITY, STATE, ZIP COD 1601 N MORRISON RD 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE ROPRIATE COM	(X5) PLETION ATE		
	resident was sitting lacked a nonslip mat HSD indicated the rupdated as she prob nonslip mat and wa mat on the recliner.  During an interview indicated the aides completion of their  During an interview 6 indicated the inter on the residents' ele aides were to click to n submit to docum.  During an interview Administrator indicated the follow driven by the service off to complete their to review residents' provide a proactive assistive devices, and minimize falls continued needs Cresidents, responsibion fall interventions documented in the reservice/care plan will be communicated.	v, on 7/19/24 at 3:39 p.m., CNA eventions and care tasks were ctronic clinical record. The the completed box, then click tent completion.  v, on 7/19/24 at 3:45 p.m., the ated the aides' tasks were e plan and were to be clicked						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
			B. WING			07/19/	/2024
NAME OF PROVIDER OR SUPPLIER  MUNCIE ESTATES SENIOR LIVING				1601 N	ADDRESS, CITY, STATE, ZIP COD MORRISON RD E, IN 47304		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	responsible party	."					
	This citation is rela	ted to complaint IN00434037					

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