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	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNCIE ESTATES SENIOR LIVING	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 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 Complaint IN00425490. Complaint IN00425490 - State Residential Finding related to the allegations is cited at R0052. Survey date: January 22 and 23, 2024 Facility number: 010886 Residential Census: 49 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 26, 2024.	R 0000	This plan of correction is not to be interpreted as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies dated 1/23/24. It is a submission of our ongoing efforts to comply with regulatory requirements. We have outlined specific actions in response to identified issues. We remain committed to the delivery of quality health care services and will continue to make changes and improvements in line with that objective.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a cognitively impaired resident (Resident B) was free of physical abuse by a staff member (LPN 1). Findings include: The clinical record for Resident B was reviewed on 1/22/24 at 11:40 a.m. Diagnoses include hypokalemia, hypothyroidism, hypertension, depression, and dementia.	R 0052	LPN #1 was immediately removed from the area and community. All residents have the potential to be affected. Community staff received re-education regarding Residents right to be free from sexual abuse, physical abuse, mental abuse, corporal punishment, neglect and	02/09/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Beeman	Health Facility Administrator	02/09/2024

Any defiencystatement 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.

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	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNCIE ESTATES SENIOR LIVING	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of a facility self-reportable, dated 1/3/24, indicated LPN 1 physically abused Resident B. Review of LPN 1's statement, dated 1/3/24, indicated while receiving resident care, Resident B became combative and struck LPN 1. LPN 1 slapped the resident across the face with an open hand. The incident was witnessed by two other staff members, HHA 3 and HHA 4. HHA 3 and HHA 4 were unavailable for interview during the survey. Review of HHA 3's written statement, dated 1/3/24, indicated she and another HHA were attempting to assist Resident B with ADL care when the resident started refusing to cooperate. LPN 1 came to assist and held the resident's wrist and hands in an attempt to stop the resident from hitting them. Resident B then reached up and smacked LPN 1. LPN 1 then smacked the resident with an open hand on her cheek an used her wrist to push her down in the recliner. LPN 1 stated she she quit and immediately left the room. Review of HHA 4's written statement, dated 1/3/24, indicated Resident B had an incontinent episode during the evening meal. The resident became combative when they attempted to move her to her room to clean her and get her ready for bed. The resident slapped LPN 1 with a hand covered in feces. LPN 1 reacted and slapped the resident in return. LPN 1 immediately left the room. During an interview on 1/22/24 at 10:37 a.m., the Administrator indicated she received a call from QMA 2 informing her of staff- to-resident abuse (LPN 1 and Resident B). QMA 2 was instructed to		involuntary seclusion was completed by the Health Services Director (Director of Nursing) on 1/5/2024. Allegations of abuse will be placed on the Resident Abuse Investigation Log and this log will be reviewed by the Executive Director monthly with the results of these reviews taken to the QAPI committee meeting for review to ensure ongoing substantial compliance.	

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	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNCIE ESTATES SENIOR LIVING	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	immediately escort LPN 1 from the facility. The Administrator and the DON immediately went to the facility and the police were called. During an interview on 1/22/24 at 1:33 p.m., the QMA 2 indicated LPN 1 reported to her she had slapped Resident B. LPN 1 told her she had been stressed, and reacted when the resident slapped her. QMA 2 called the Administrator and the DON, and was instructed to escort LPN 1 from the facility immediately. Review of a current policy, dated 11/1/2014, titled "Resident Abuse and Neglect" was provided by the Administrator on 1/22/24 at 10:37 a.m., and indicated the following: " .... Definition...1. Abuse: the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrated physical harm, pain, or mental anguish, tit will be assumed that the abuse caused physical harm, pain, or mental anguish. Abuse includes physical abuse, sexual abuses, mental abuse, and exploitation of a vulnerable adult, which have the following meanings: ....C. Physical Abuse: Any willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes but is not limited to striking with or without an object, slapping, kicking, pinching, choking, grabbing, shoving, or prodding. ...." This citation relates to Complaint IN00425490.			