

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/27/2026	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE PLACE - MUNCIE		STREET ADDRESS, CITY, STATE, ZIP CODE 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: August 26 and 27, 2026 Facility number: 014463 Residential Census: 41 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 31, 2026.	R 0000					
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The	R 0121	Facility will change current Tb form for staff to include the time of administration and time read. To ensure that residents have not been exposed to Tb from employees a Tb risk assessment will be done. All Tb tests for staff			10/31/2026	

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result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:

(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.

(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work

moving forward will include the time of administration and time read to ensure timely interpretation. All staff responsible for administering and reading TB tests will be educated on the TB testing procedure and the requirement to document the date and time the TB test is administered and the date and time the test is read, along with all other required information. Each time a Tb test is administered, the DON and Executive Director will audit the form including verification that the administration time and reading time are documented. Also, that the 2nd step is administered in the 21-day time frame.

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until tuberculosis is ruled out.

Based on interview and record review, the facility failed to ensure employees had current and valid Tuberculosis (TB) skin testing completed for 2 of 3 employees reviewed for TB skin testing (Certified Nursing Assistant (CNA) 4 & CNA 5).

Findings Include:

1. The record for CNA 4 was reviewed on 8/27/26 at 11:05 a.m. A 1st step TB skin test was administered on 11/23/24 and did not include the time of administration. The 1st step TB skin test was read on 11/25/24 and did not include the time it was read. No 2nd step TB skin test was administered within 21 days of the 1st step TB skin test being read.

2. The record for CNA 5 was reviewed on 8/27/26 at 11:10 a.m. A 1st step TB skin test was administered on 3/26/26 and did not include the time of administration. The 1st step TB skin test was read on 3/28/26 and did not include the time it was read. No 2nd step TB skin test was administered within 21 days of the 2nd step TB skin test being read.

During an interview, on 8/27/26 at 11:59 a.m., the Executive Director (ED) indicated there

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	was no second step TB skin test administered within the time frame of 21 days. The facility forms did not have a space to put the time the TB test was administered or read, and it should be there. The facility policy needed updated to include the time. A current, undated facility policy titled "TB Screening," received from the Director of Nursing (DON) on 8/27/26 at 12:21 p.m., indicated " ... will ensure the following: At the time of employment ... employees and non-paid personnel of facilities shall be screened for tuberculosis ... If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step"			
R 0269	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(b) (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietitian.	R 0269	The facility will implement a process whereby the pureed diet substitution menu will be submitted to the Registered Dietitian for review and approval as part of the quarterly regular menu review. The Dietary Manager will ensure the pureed substitution menu is provided to the Registered Dietitian at the time of each quarterly menu review and that the RD's review and approval are documented. The facility will	10/31/2026

Based on observation, interview, and record review the facility failed to ensure menu substitutions for a texture-modified diet were approved by the dietitian for 1 of 1 residents reviewed for pureed diets (Resident 20).

Findings included:

During a pureed food preparation observation, on 8/26/26 at 11:01 a.m., the Dietary Manager placed a chicken breast in the food processor. She indicated the pepperoni pizza listed on the menu did not puree well, so she always used chicken instead. After pureeing the chicken, she placed the chicken into a small container and placed the container on the steam table. She then placed cooked beets into the food processor and indicated she was using them as a substitute for the chopped salad listed on the menu. After pureeing the beets, she placed them into a small container on the steam table. She indicated she was serving mashed potatoes as the starch component of the meal.

The facility lunch menu, provided by the Administrator on 8/26/26, indicated the lunch menu was pepperoni pizza, chopped salad, garlic bread, and peach dump cake.

review all residents currently receiving a pureed diet to identify those who may have been affected by the use of pureed diet substitutions that had not been reviewed and approved by the Registered Dietitian. Any other resident on a puree diet will be served from the approved substitution menu. The Dietary Manager will be responsible for ensuring the pureed substitution menu is submitted to the Registered Dietitian, and that documentation of the RD's review and approval is maintained. Dietary staff will be educated by dietary manager, following the RD-approved pureed substitution menu and will be instructed to notify the Dietary Manager of any needed changes or substitutions. The Dietary Manager will monitor compliance by reviewing puree diet substitutions are being followed, twice a month for the next quarter.

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On 8/27/26 at 10:44 a.m., the Dietary Manager provided a facility menu for the spring/summer week 3 of 4 and indicated the menu was used for all diet types. The menu did not include a separate pureed diet menu. A statement at the bottom of the menu indicated, "Modifications will be made for each meal for anyone receiving Texture Modified Diets."

On 8/27/26 at 11:14 a.m., the Dietary Manger indicated the menu was generally the same for both regular and pureed diets. If a resident did not like what was being served, or if the staff observed the resident ate another item better, she substituted foods. She identified grilled cheese, hot dogs, hamburgers and other foods as alternatives. She ensured the substituted meals included a three-ounce protein, a vegetable, a starch, and a dessert. She did not have a list of dietitian-approved substitutions for pureed diet menu items.

Review of the spring/summer week 3 of 4 menu, provided by the Dietary Manager on 8/27/26 at 11:14 a.m., indicated alternative items included grilled cheese sandwich, split hot dogs, hamburger/cheeseburger, peanut butter and jelly, ham/turkey sandwich, and fish

filed on a bun. The menu also indicated that cereal, grilled cheese sandwich, hamburger/cheeseburger, peanut butter and jelly and leftovers were always available.

On 8/27/26 at 12:02 p.m., the Administrator indicated the dietitian visited the facility as required by regulations. She was unable to locate, in the dietitian's report, a list of substitutes approved by the dietitian for pureed diets or documentation showing dietitian approval of pureed diet substitutions.

On 8/27/26 at 12:26 p.m., the Administrator indicated the Dietary Manager had recently created a menu indicating what residents receiving a finger-food diet should receive in place of the regular menu items and was working on a similar substitution menu for residents requiring pureed diets. The substitution menu had not been approved by the dietitian.

A current facility policy, dated 2020, titled "Menu Substitutions or Changes and Approval," provided by the Administrator on 8/27/26 at 12:02 p.m., indicated the following: "...The consultant registered dietitian may assign the task of selecting and making proper, nutritionally equivalent menu substitutions or menu

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	changes to a qualified nutrition support staff member. The registered dietitian is available to the qualified nutrition support staff member for questions or clarifications regarding any menu substitutes or menu changes as needed, and reviews the substitutions/changes periodically and signs off on the changes ...Permanent menu changes are made for instances such as long periods of a specific food item being unavailable, resident preferences or complaints, etc. b. When making permanent changes to the menu, the appropriate spreadsheets are also modified or new spread sheets are created and approved by the registered dietitian for those days reflecting the permanent menu changes. Additionally, new corresponding recipes for the new menu items are generate/obtained as well, including Dental Soft (Mechanical Soft) and Pureed recipes (if applicable)"			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name.	R 0301	Upon identification, the medication was removed from use and anew bottle of the medication with a complete and legible pharmacy label was obtained by	09/21/2026

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(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, interview and record review, the facility failed to ensure medication was labeled with medication instructions and an expiration date in 1 of 1 medication cart reviewed for medication storage (200 hall cart). During a medication storage observation with Qualified Medication Aide (QMA) 2, on 8/26/26 at 12:41 p.m., a bottle of medication with a faded label was in the narcotic drawer in the 200 hall cart. The directions "every 4 hours PRN (as needed)" were handwritten in ink on the side of the bottle under the resident's name. The expiration date and printed directions were not visible. The resident's name, most of the	order of MD and placed into use.The facility will conduct a comprehensive review of all residents' medication storage areas and medication containers to identify any additional medications with labels that are damaged, worn, illegible, or otherwise difficult to read. All identified medications will be removed from use until the medication information can be verified and the label replaced or corrected by the appropriate staff/pharmacy.DON will complete the comprehensive review.Staff will be instructed that all medication containers must have clean, intact, and legible labels at all times. Medications with damaged, missing, or illegible labels will not be administered until the medication and labeling have been appropriately verified and corrected. All applicable staff will be educated on the requirement to inspect medication labels for legibility and integrity and to promptly report and remove from use any medication container with a damaged or illegible label. Medication storage areas will be inspected routinely by staff to ensure labels remain intact and	
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	prescription number and part of the medication name was faded, but legible. During an observation, on 8/26/26 at 12:16 p.m., the Director of Nursing observed the faded label and indicated she was unable to read the original instructions. They should not be handwritten in and no date was legible. During an interview, on 8/26/26 at 12:41 p.m., QMA 2 indicated the medication was alprazolam, and per the narcotic count sheet, the medication expired on 11/30/26. She could not read the date on the bottle. She had not seen a label fade that way, and labels should be legible. During an interview, on 8/26/26 at 12:08 p.m., the Executive Director indicated she had noticed the faded label the last time she passed medications on the hall and forgot to mention it to anyone.		legible. Any discrepancies identified will be reported to the director of nursing and corrected immediately. Once a quarter DON will conduct a cart check to monitor for label discrepancies.	
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the	R 0410	Facility will change current Tb form to include the time of administration and time read. All Tb tests for residents moving forward will include the time of administration and time read to ensure timely interpretation. All staff responsible for	09/21/2026

date given, date read, and by whom administered and read.

(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

Based on record review and interview, the facility failed to document the time of administration and time read of tuberculin skin tests (TST) performed to ensure timely interpretation per professional guidelines for 4 of 7 residents reviewed for TST administration. (Residents 1, 15, 39, and 42)

1. Resident 1's clinical record was reviewed on 8/26/26 at 1:20 p.m. The first step TST was performed on 8/20/26 and read on 8/22/26. The test administered did not include the times administered or read.

2. Resident 15's clinical record was reviewed on 8/27/26 at

administering or reading TB tests will be educated on the TB testing procedure and the requirement to document the date and time the TB test is administered and the date and time the test is read, along with all other required information. Each time a Tb test is administered, the DON and Executive Director will audit the form including verification that the administration time and reading time are documented.

9:00 a.m. The first step TST was performed on 1/26/26 and read on 1/29/26. The test administered did not include the times administered or read. The second step TST was performed on 2/19/26 and read on 2/22/26. The test administered did not include the times administered or read.

3. Resident 39's clinical record was reviewed on 8/26/26 at 1:00 p.m. The first step TST was performed on 8/5/26 and read on 8/7/26. The test administered did not include the times administered or read.

4. Resident 42's clinical record was reviewed on 8/27/26 at 9:45 a.m. The first step TST was performed on 6/8/26 and read on 6/10/26. The test administered did not include the times administered or read. The second step TST was performed on 7/7/26 and read on 7/9/26. The test administered did not include the times administered or read.

During an interview with the Administrator, on 8/27/26 at 11:59 a.m., she indicated the facility's tuberculin skin test forms did not include a place for the time of administration to be documented.

A current facility policy, titled "Infection Control - Communicable Disease",

provided by the Administrator on 8/27/26 at 12:21 p.m., indicated the following: " ... (facility name) has established and maintains an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infections ...EACH resident shall have a diagnostic chest x-ray completed no more than six months prior to admission. A tuberculin skin test shall be completed within three months prior to admission or upon admission and read at forty-eight and seventy-two hours. The results shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read ... For residents who have not had a documented negative tuberculin skin test result during the proceeding twelve months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one to three weeks after the first test"

According to the Centers for Disease Control and Prevention, retrieved from <https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html> on 8/27/27 at 2:10 p.m., " ... If the first TB skin test result

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	is negative, a second TB skin test should be done 1 to 3 weeks later"			
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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 SIGNATUREBailey Thompson	TITLEDirector of Nursing	(X6) DATE09/10/2026
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