STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155242		î ´	A. BUILDING CO B. WING 02		DATE SURVEY COMPLETED 02/17/2025	
	PROVIDER OR SUPPLIER		430	EET ADDRESS, CITY, STATE, ZIP COE 1 N WALNUT ST NCIE, IN 47303	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
E 0000	conducted by the In accordance with 42 Survey Date: 02/17 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency Signature Healthcar compliance with Er Requirements for M Participating Provid 483.73. The facility census of 128 at the Quality Review cor	27/25 20146 255242 291200 Preparedness survey, re of Muncie was found not in mergency Preparedness dedicare and Medicaid ders and Suppliers, 42 CFR has a capacity of 140 and had a time of this survey.	E 0000	This plan of correction is center's credible allegatic compliance. Preparation execution of this plan of does not constitute admis agreement by the provide truth of the facts alleged conclusions set forth in the statement of deficiencies plan of correction is prepor executed solely because required by the provision federal and state law Due to the scope and set the findings, facility respectively.	on of and or correction ssion or er of the or ne . The ared and use it is s of verity of ectfully	
E 0037 SS=F Bldg	Based on record reversitied to conduct and Emergency Prepare facility must do all training in emergen procedures to all neindividuals providinand volunteers, con roles; (ii) Provide e training at least and documentation of a training; (iv) Demo emergency procedures	riew and interview, the facility nual training for the dness Program (EPP). The LTC of the following: (i) Initial cy preparedness policies and w and existing staff, ng services under arrangement, sistent with their expected mergency preparedness	E 0037	No residents, staff or were affected by this alle deficient practice. The Maintenance Director or will provide and documer annual Emergency Prepa (EP) training for facility standard All Residents, staff a visitors have the potential affected by this alleged depractice. The Maintenance Director or Designee will EP training of staff included documentation of the standard present and the standard	actice. The ce Director or Designee and document an ergency Preparedness g for facility staff. sidents, staff and re the potential to be this alleged deficient ne Maintenance Designee will audit the of staff including tion of the staff EP	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE

(X6) DATE

Daphne New Administrator 03/06/2025

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155242		B. WING		02/17/2025		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP COD 4301 N WALNUT ST MUNCIE, IN 47303					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECHLATORY OR USE UPENITIEVING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			TE	(X5) COMPLETION DATE	
	REGULATORY OR LSC IDENTIFYING INFORMATION all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 02/17/25 at 10:11 a.m., no documentation of an annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director and the Administrator stated the EPP training was not conducted within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			training to ensure documentation is kept available during normal business hours for review by the AHJ The Regional Plant Operations Director will in-sent the Maintenance Director on documentation of annual EP training, and The Maintenance Director or Designee, will audit annual EP training documentation weekly one month, then monthly for 3 months or until substantial compliance is achieved to ensit is available during normal business hours to be reviewed Authority Having Jurisdiction (AHJ). Annual training documentation be retained for three years. Maintenance Director or Designee will provide copies of EP training program audits to a EP training program audit	nhe vice vice vice vice vice vice vice			
E 0039 SS=C Bldg	EP Testing Requir							
	Term Care (LTC) fa facility's response to documentation of al Program (EPP) drill following: (i) Participate in an is community-based	riew and interview, the Long acility failed analyze the o and maintain complete all Emergency Preparedness as. The LTC facility must do the annual full-scale exercise that all; or atty-based exercise is not	E 00)39	No residents, staff or visite were affected by this alleged deficient practice. Maintenance Director will ensure documents for both annual exercises conducted on 5/16/24 and 8/30 are amended to include a description of the scenario and analysis the staff followed the	e ation 0/24	03/26/2025	

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING		COMPLETEI)
		155242	B. WING 02/17/2025			5	
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			WALNUT ST		
SIGNATU	JRE HEALTHCARE	OF MUNCIE			E, IN 47303		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			_	ID	ī	<u> </u>	(V5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		CO	(X5) MPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO.	DATE
TAG		an annual individual,		IAG	EPP, to ensure the policies we	are	DATE
	facility-based funct				effective.	516	
	1	y experiences an actual natural			All residents, staff and		
		gency that requires activation			visitors had the potential to be		
	_	lan, the LTC facility is exempt			affected by this alleged deficie		
		ext required full-scale in a			practice. The Maintenance	,,,,,,	
		or individual, facility-based			Director or designee will audit	the	
		l exercise for 1 year following			EP testing procedures to ensu		
	the onset of the actu				documentation instructions		
		itional exercise that may			include scenario and analysis	of	
	1 ' '	imited to the following:			staff following EPP, to ensure		
	a. A second full-sca	_			policies were effective		
		or an individual, facility-based			The Regional Plant		
	functional exercise.				Operations Director will in-ser	vice	
	b. A mock disaster	drill; or			the Maintenance Director on		
	c. A tabletop exerci	se or workshop that is led by a			documenting EP testing		
	facilitator that inclu	des a group discussion, using			requirements and		
	a narrated, clinically	y-relevant emergency scenario,			The Maintenance Director or		
	and a set of problen	n statements, directed			Designee will audit EP training	a	
	messages, or prepar	red questions designed to			requirements weekly for one		
	challenge an emerge	ency plan.			month, then monthly for three		
		CC facility's response to and			months or until substantial		
		ation of all drills, tabletop			compliance is achieved to ens	ure	
		gency events, and revise the			it contains scenario and analy		
		gency plan, as needed in			of staff following EPP to ensur	re	
		CFR 483.73(d)(2). This			policies were effective.		
	deficient practice co	ould affect all occupants.			The Maintenance Director		
					provide copies of the EP testir	ng	
	Findings include:				requirements audits to the		
	D 1 ,	t that Alltha			facility's QAPI committee,		
		eview with the Administrator			monthly until substantial		
		e Director on 02/17/25 at 10:31			compliance is achieved.		
		n for both annual exercises					
		/24 and on 08/30/24 were					
	_	cercises did not describe the					
		er the facility's response was					
	1 -	the staff followed the EPP to					
		were effective. Based on an					
		e of records review, the					
	Maintenance Director and the Administrator				1		

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

PRINTED: 03/10/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155242		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/17/2025	
	PROVIDER OR SUPPLIER JRE HEALTHCARE		4301 N	ADDRESS, CITY, STATE, ZIP COD I WALNUT ST IE, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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
		ation for analyzing the LTC			
		viewed with the Administrator irector during the exit			
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 02/17 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety 0 Healthcare of Munc compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L building was survey Health Care Occupa This one story facilit Type V (000) const: The facility has a fin detection in corrido and battery operated resident rooms. The and had a census of	200146 55242 91200 Code survey, Signature tie was found not in equirements for Participation in 42 CFR Subpart 483.90(a), tre, the 2012 edition of the extion Association (NFPA) 101, and 410 IAC 16.2. The great with Chapter 19 Existing	K 0000	This plan of correction is the center's credible allegation of compliance. Preparation and execution of this plan of corredoes not constitute admission agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared or executed solely because it required by the provisions of federal and state law Due to the scope and severity the findings, facility respectfur equests paper/desk compliance.	ection n or the and is sis

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155242 B. WING 02/17/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4301 N WALNUT ST SIGNATURE HEALTHCARE OF MUNCIE MUNCIE. IN 47303 SUMMARY STATEMENT OF DEFICIENCIE (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 02/20/25 K 0345 **NFPA 101** SS=F Fire Alarm System - Testing and Bldg. 01 Maintenance Based on record review and interview, the facility K 0345 No residents, staff or visitors 03/26/2025 failed to ensure 1 of 1 fire alarm systems were were affected by this alleged maintained in accordance with LSC 9.6.1.3 which deficient practice. The requires a fire alarm system to be installed, tested, Maintenance Director will ensure and maintained in accordance with NFPA 70, the facility's fire alarm vendor National Electrical Code and NFPA 72, National provides documentation for the Fire Alarm Code. NFPA 72, Section 14.4.5 states smoke detector sensitivity testing unless otherwise permitted by other sections of for all 93 smoke detectors, that this Code, testing shall be performed in includes sensitivity range and accordance with the schedules in Table 14.4.5, or sensitivity testing point and that more often if required by the authority having documentation for the sensitivity jurisdiction. Section 14.4.5.3.1 states smoke testing is kept available during detector sensitivity shall be checked within 1 year normal business hours for review after installation. Section 14.4.5.3.2 states smoke by the AHJ, for a period of twelve detector sensitivity shall be checked every years (three cyclers) alternate year thereafter unless otherwise All residents, staff and permitted by compliance with Section 14.4.5.3.3. visitors have the potential to be Section 14.4.5.3.5 states unless otherwise affected by this alleged deficient permitted by 14.4.5.3.6, smoke detectors or smoke practice. The Maintenance alarms found to have a sensitivity outside the Director or designee will audit the listed and marked sensitivity range shall be smoke detector sensitivity report cleaned and recalibrated or be replaced. This provided by the facility's fair alarm deficient practice could affect all occupants. vendor to ensure all smoke detectors are documented and Findings include: report indicates sensitivity range and sensitivity set point for each Based on records review with the Maintenance smoke detector listed. Director and the Administrator on 02/17/25 at The Regional Plant 11:24 a.m., the documentation for the smoke Operations Director will in-service detector sensitivity testing stated the facility the Maintenance Director on

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contained 93 smoke detectors but only 43 were

tested for sensitivity. Also, the smoke detectors

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documenting two-year smoke

detector sensitivity testing and

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CENTERS FOR	R MEDICARE & MEDIC					OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
		155242	B. WI	B. WING		02/17/	/2025
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			4301 N	ADDRESS, CITY, STATE, ZIP COD WALNUT ST IE, IN 47303			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	(IE	DATE
	with completed sen	sitivity did not show the			The Maintenance Director or		
	_	or the sensitivity testing point.			designee will audit two-year		
		at the time of record review,			smoke detector sensitivity tes	tina	
		rector stated the sensitivity			documentation weekly for one	-	
		all smoke detectors could not			month, then monthly for three		
		d the testing form did not			months or until substantial		
		range nor the sensitivity			compliance is achieved to en	sure	
	testing point,	į,			it is kept available during norr		
					business hours for review by		
	This finding was re	viewed with the Administrator			AHJ, for a period of twelve ye		
	and Maintenance D			The Maintenance Directo			
conference.					provide copies of the smoke		
					detector sensitivity audits to the	ne	
	3.1-19(b)			facility's QAPI committee,			
					monthly until substantial		
					compliance is achieved		
K 0346	NFPA 101						
SS=C	Fire Alarm Systen	n - Out of Service					
Bldg. 01							
		view and interview, the facility	K 0.	346	No residents, staff or visit	tors	03/26/2025
	_	complete written fire watch			were affected by this alleged		
	policy for the protection of residents indicating				deficient practice. The		
	^	llowed in the event the fire			Maintenance Director will ens		
	-	be placed out of service for			documentation for fire watch		
		in a twenty-four hour period in			contains contacting the Indiar		
		SC, Section 9.6.1.6. This			Dept of Health (ISDH) via the	ir	
	deficient practice at	ffects all occupants.			gateway at		
					https://gateway.idoh.in.gov		
	Findings include:				(primary) or completing and		
					emailing the incident reporting	•	
		eview with the Maintenance			form to incidents@health.in.g		
		lministrator on 02/17/25 at			when the fire alarm system is		
	· ·	watch plan failed to include			of service for more than four h	nours.	
	_	ana Department of Health via			All residents, staff and		
	the IDOH Gateway				visitors have the potential to b		
		h.in.gov as the primary			affected by this alleged deficie	ent	
		econdary method when the			practice. The Maintenance		
	IDOH Gateway is r	IDOH Gateway is nonoperational by completing			Director or Designee will audi	t the	

the Incident Reporting form and e-mailing it to

fire watch procedures to ensure

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED		
		155242	B. WIN	G		02/17/	2025
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
SIGNATU	JRE HEALTHCARE	OF MUNCIE			WALNUT ST E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	.gov. Based on interview			documentation instructions		
	-	view, the Maintenance			include contacting the ISDH vi	а	
		ministrator acknowledged the			their gateway at		
		tation provided stated to			https://gateway.idoh.in.gov		
		ot via the IDOH Gateway link			(primary) or completing and		
	or at the e-mail add	ress listed above.			emailing the incident reporting		
	751 · 6 · 1 ·				form to incidents@health.in.go		
		viewed with the Administrator			when the fire alarm system is		
		irector during the exit			of service for more than 4 hou	rs in	
	conference.				a 24 hour period.		
	3.1-19(b)				The Regional Plant		
	3.1-19(0)				Operations Director will in-sen the Maintenance Director on fi		
					watch procedures including	ie	
					contacting the ISDH via their		
					gateway at		
					https://gateway.idoh.in.gov		
					(primary) or completing and		
					emailing the incident reporting		
					form to incidents@health.in.go		
					when the fire alarm system is		
					of service for more than 4 hou		
					a 24 hour period and		
					The Maintenance Director or		
					Designee will audit fire watch		
					procedure weekly for one mor	ıth,	
					then monthly for three months	or	
					until substantial compliance is		
					achieved to ensure it contains		
					contacting the ISDH via their		
					gateway at		
					https://gateway.idoh.in.gov		
					(primary) or completing and		
					emailing the incident reporting		
					form to incidents@health.in.go		
					when the fire alarm system is		
					of service for more than 4 hou	rs in	
					a 24 hour period		
					The Maintenance Director		
					provide copies of the fire alarn	n out	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155242		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/17/2025	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
SIGNATI	JRE HEALTHCARE	OF MUNCIE		IE, IN 47303	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	of service fire watch procedure audits to the facility's QAPI committee, monthly until substantial compliance is achieved.	DATE
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System -	- Out of Service			
	failed to provide a compolicy for the protect procedures to be fol automatic sprinkler out-of-service for 10 period in accordance 9.7.6 requires sprinkler comply with NFPA for the Inspection, The Water-Based Fire Procedures a fire water personnel who contains area. Ready access the area, the person for fire, but making protection features or routes and alarm system functioning properly affect all occupants. Based on records reprocedures to the Additional procedures and the Additional procedures.	view with the Maintenance ministrator on 02/17/25 at	K 0354	No residents, staff or visited were affected by this alleged deficient practice. The Maintenance Director will ensure documentation for fire watch placentains contacting the Indiana Dept of Health (ISDH) via their gateway at https://gateway.idoh.in.gov (primary) or completing and emailing the incident reporting form to incidents@health.in.gov when the sprinkler system is or of service for more than 10 hou in a 24 hour period All residents, staff and visitors have the potential to be affected by this alleged deficient practice. The Maintenance Director or designee will audit fire watch procedures to ensure documentation instructions include contacting the ISDH via their gateway at https://gateway.idoh.in.gov (primary) or completing and emailing the incident reporting form to incidents@health.in.gov (primary) or completing and emailing the incident reporting form to incidents@health.in.gov (primary) or sprinkler system is on the sprinkler sy	vuturs ent the e
		watch plan failed to include		of service for more than 10 hou	
	contacting the India	na Department of Health via	1	in a 24 hour period.	

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PRINTED: 03/10/2025 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155242	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/17/2025	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			4301 1	ADDRESS, CITY, STATE, ZIP COD N WALNUT ST CIE, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The Regional Plant	(X5) COMPLETION DATE	
	method or by the so IDOH Gateway is the Incident Report incidents@health.induring the record red Director and the Adfire watch documer contact IDOH but to at the e-mail add.	h.in.gov as the primary econdary method when the nonoperational by completing ing form and e-mailing it to n.gov. Based on interview eview, the Maintenance dministrator acknowledged the ntation provided stated to not via the IDOH Gateway link		The Regional Plant Operations Director will in-ser the Maintenance Director on f watch procedures including contacting the ISDH via their gateway at https://gateway.idoh.in.gov (primary) or completing and emailing the incident reporting form to incidents@health.in.go when the sprinkler system is o of service for more than 10 ho in a 24 hour period. The Maintenance Directo designee will audit fire watch procedures weekly for one mo then monthly for three months until substantial compliance is achieved to ensure it contains contacting the ISDH via their gateway at https://gateway.idoh.in.gov (primary) or completing and emailing the incident reporting form to incidents@health.in.go when the sprinkler system is o of service for more than 10 ho in a 24 hour period. The Maintenance Directo provide copies of the sprinkler system out of service fire watc procedure audits to the facility QAPI committee, monthly until substantial compliance is achieved.	pov but burs r or onth, s or s s but burs r will ch	

Event ID: 0CQ321 Facility ID: 000146 If continuation sheet Page 9 of 9