STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155242	A. BUILDING -- B. WING	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/17/25 Facility Number: 000146 Provider Number: 155242 AIM Number: 100291200 At this Emergency Preparedness survey, Signature Healthcare of Muncie was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 140 and had a census of 128 at the time of this survey. Quality Review completed on 02/20/25	E 0000	This plan of correction is the center's credible allegation of compliance. Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law Due to the scope and severity of the findings, facility respectfully requests paper/desk compliance	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect	E 0037	No residents, staff or visitors were affected by this alleged deficient practice. The Maintenance Director or Designee will provide and document an annual Emergency Preparedness (EP) training for facility staff. All Residents, staff and visitors have the potential to be affected by this alleged deficient practice. The Maintenance Director or Designee will audit the EP training of staff including documentation of the staff EP	03/26/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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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	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-service the Maintenance Director on documentation of annual EP training, and The Maintenance Director or Designee, will audit annual EP training documentation weekly for one month, then monthly for 3 months or until substantial compliance is achieved to ensure it is available during normal business hours to be reviewed by Authority Having Jurisdiction (AHJ). Annual training documentation will be retained for three years. Maintenance Director or Designee will provide copies of the EP training program audits to the Facility's QAPI committee, monthly until substantial compliance is achieved.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the Long Term Care (LTC) facility failed analyze the facility's response to and maintain complete documentation of all Emergency Preparedness Program (EPP) drills. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not	E 0039	No residents, staff or visitors were affected by this alleged deficient practice. Maintenance Director will ensure documentation for both annual exercises conducted on 5/16/24 and 8/30/24 are amended to include a description of the scenario and an analysis the staff followed the	03/26/2025

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	155242	A. BUILDING -- B. WING	02/17/2025

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SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

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	accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 02/17/25 at 10:31 a.m., documentation for both annual exercises conducted on 05/16/24 and on 08/30/24 were incomplete. Both exercises did not describe the scenario and whether the facility's response was analyzed to ensure the staff followed the EPP to ensure the policies were effective. Based on an interview at the time of records review, the Maintenance Director and the Administrator		EPP, to ensure the policies were effective. All residents, staff and visitors had the potential to be affected by this alleged deficient practice. The Maintenance Director or designee will audit the EP testing procedures to ensure documentation instructions include scenario and analysis of staff following EPP, to ensure policies were effective The Regional Plant Operations Director will in-service the Maintenance Director on documenting EP testing requirements and The Maintenance Director or Designee will audit EP training requirements weekly for one month, then monthly for three months or until substantial compliance is achieved to ensure it contains scenario and analysis of staff following EPP to ensure policies were effective. The Maintenance Director will provide copies of the EP testing requirements audits to the facility's QAPI committee, monthly until substantial compliance is achieved.	

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	stated no documentation for analyzing the LTC facility's response was completed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/17/25 Facility Number: 000146 Provider Number: 155242 AIM Number: 100291200 At this Life Safety Code survey, Signature Healthcare of Muncie was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor, and battery operated smoke detectors in the resident rooms. The facility has a capacity of 140 and had a census of 128 at the time of this survey. All areas where the residents have customary	K 0000	This plan of correction is the center's credible allegation of compliance. Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law Due to the scope and severity of the findings, facility respectfully requests paper/desk compliance	

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	155242	A. BUILDING 01 B. WING	02/17/2025

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	access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 02/20/25			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems were maintained in accordance with LSC 9.6.1.3 which requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. Section 14.4.5.3.5 states unless otherwise permitted by 14.4.5.3.6, smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 02/17/25 at 11:24 a.m., the documentation for the smoke detector sensitivity testing stated the facility contained 93 smoke detectors but only 43 were tested for sensitivity. Also, the smoke detectors	K 0345	No residents, staff or visitors were affected by this alleged deficient practice. The Maintenance Director will ensure the facility's fire alarm vendor provides documentation for the smoke detector sensitivity testing for all 93 smoke detectors, that includes sensitivity range and sensitivity testing point and that documentation for the sensitivity testing is kept available during normal business hours for review by the AHJ, for a period of twelve years (three cyclers) All residents, staff and visitors have the potential to be affected by this alleged deficient practice. The Maintenance Director or designee will audit the smoke detector sensitivity report provided by the facility's fair alarm vendor to ensure all smoke detectors are documented and report indicates sensitivity range and sensitivity set point for each smoke detector listed. The Regional Plant Operations Director will in-service the Maintenance Director on documenting two-year smoke detector sensitivity testing and	03/26/2025

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	with completed sensitivity did not show the sensitivity range nor the sensitivity testing point. Based on interview at the time of record review, the Maintenance Director stated the sensitivity documentation for all smoke detectors could not be found and agreed the testing form did not show the sensitivity range nor the sensitivity testing point, This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		The Maintenance Director or designee will audit two-year smoke detector sensitivity testing documentation weekly for one month, then monthly for three months or until substantial compliance is achieved to ensure it is kept available during normal business hours for review by th AHJ, for a period of twelve years. The Maintenance Director will provide copies of the smoke detector sensitivity audits to the facility's QAPI committee, monthly until substantial compliance is achieved	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete written fire watch policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 02/17/25 at 11:35 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.idoh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to	K 0346	No residents, staff or visitors were affected by this alleged deficient practice. The Maintenance Director will ensure documentation for fire watch plan contains 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 fire alarm system is out of service for more than four hours. All residents, staff and visitors have the potential to be affected by this alleged deficient practice. The Maintenance Director or Designee will audit the fire watch procedures to ensure	03/26/2025

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	incidents@health.in.gov. Based on interview during the record review, the Maintenance Director and the Administrator acknowledged the fire watch documentation provided stated to contact IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		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 when the fire alarm system is out of service for more than 4 hours in a 24 hour period. The Regional Plant Operations Director will in-service the Maintenance Director on fire 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.gov when the fire alarm system is out of service for more than 4 hours in a 24 hour period and The Maintenance Director or Designee will audit fire watch procedure weekly for one month, 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.gov when the fire alarm system is out of service for more than 4 hours in a 24 hour period The Maintenance Director will provide copies of the fire alarm out	

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			of service fire watch procedure audits to the facility's QAPI committee, monthly until substantial compliance is achieved.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide a complete written fire watch policy for the protection of residents, indicating procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and the Administrator on 02/17/25 at 11:35 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via	K 0354	No residents, staff or visitors were affected by this alleged deficient practice. The Maintenance Director will ensure documentation for fire watch plan contains 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 out of service for more than 10 hours 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 the 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 when the sprinkler system is out of service for more than 10 hours in a 24 hour period.	03/26/2025

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	the IDOH Gateway link at https://gateway.idoh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on interview during the record review, the Maintenance Director and the Administrator acknowledged the fire watch documentation provided stated to contact IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		The Regional Plant Operations Director will in-service the Maintenance Director on fire 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.gov when the sprinkler system is out of service for more than 10 hours in a 24 hour period. The Maintenance Director or designee will audit fire watch procedures weekly for one month, 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.gov when the sprinkler system is out of service for more than 10 hours in a 24 hour period. The Maintenance Director will provide copies of the sprinkler system out of service fire watch procedure audits to the facility's QAPI committee, monthly until substantial compliance is achieved.	