PRINTED: 10/24/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155242	B. WI	NG	_	09/28	/2023
NAME OF F	DROLUBER OR GURRI IEI		-	STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	K	4301 N WALNUT ST				
	JRE HEALTHCARE	E OF MUNCIE		MUNC	IE, IN 47303		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
Diag. 00	This visit was for t	he Investigation of Complaints	F 00	000	It is the practice of this provide	ar to	
	IN00418061 and IN	-	1 00	<i>,</i>	ensure that federal participation		
	I 100 110001 unu II				requirements for nursing home		
	Complaint IN0041	8061 - Federal/State deficiencies			participating in Medicare &/or		
	_	ations are cited at F580.			Medicaid programs are met in		
					accordance with federal and s		
	Complaint IN0041	7645 - Federal/State deficiencies			law.		
	related to the allega	ations are cited at F600.			This provider respectfully requ	iests	
					that this CMS-2567 Plan of		
	Unrelated deficient	cies are cited.			Correction be considered		
					the Letter of Credible Allegation		
	Survey dates: Septe	ember 26, 27 and 28, 2023.			Compliance and requests a de		
	Facility number: 00	20146			review in lieu of a post-survey		
	Provider number: 1				review on, or after 10/18/2023	٠.	
	AIM number: 1002						
	7 thvi namoer. 1002	291200					
	Census Bed Type:						
	SNF/NF: 118						
	Total: 118						
	Census Payor Type	e:					
	Medicare: 11						
	Medicaid: 90						
	Other: 17						
	Total: 118						
	These deficiencies	reflect State Findings cited in					
	accordance with 41	_					
	accordance with 41						
	Quality review con	npleted October 6, 2023.					
F 0580	483.10(g)(14)(i)-(i	iv)(15)					
SS=D		s (Injury/Decline/Room, etc.)					
Bldg. 00		otification of Changes.					1
	- ,-,, ,	immediately inform the					

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

resident; consult with the resident's

(X6) DATE

TITLE

Eric Ahlbrand **CEO-Administrator** 10/23/2023

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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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 09	938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î	CONSTRUCTION	(X3) DATE SURVEY	7
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155242	B. WING		09/28/2023	
NAME OF I	PROVIDER OR SUPPLIEI	R	STREET	ADDRESS, CITY, STATE, ZIP	COD	
				N WALNUT ST		
SIGNATI	URE HEALTHCARE	E OF MUNCIE	MUNC	CIE, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	ORRECTION (	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMP	LETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		ATE
		tify, consistent with his or				
	her authority, the	resident representative(s)				
	when there is-					
	1 ' '	volving the resident which				
	1	nd has the potential for				
	requiring physicia					
	. , -	change in the resident's				
	1 ' '	or psychosocial status				
		ration in health, mental, or				
	1 ' '	us in either life-threatening				
		cal complications);				
	` '	er treatment significantly				
	form of treatment	discontinue an existing				
	of treatment); or	r to commence a new form				
	, .	transfer or discharge the				
		facility as specified in				
	§483.15(c)(1)(ii).	facility as specified in				
	- , , , , , ,	notification under paragraph				
		ection, the facility must				
	1471 717	rtinent information specified				
	· · · · · · · · · · · · · · · · · · ·	s available and provided				
	upon request to the	•				
		ust also promptly notify the				
		resident representative, if				
	any, when there is					
	(A) A change in ro	oom or roommate				
	assignment as sp	ecified in §483.10(e)(6); or				
	(B) A change in re	esident rights under Federal				
		gulations as specified in				
	paragraph (e)(10)					
		ust record and periodically				
	•	ss (mailing and email) and				
	phone number of					
	representative(s).					
	\$402.40(~\/45\					
	§483.10(g)(15)	omposite distinct part. A				
		mposite distillot part. A	- 1			

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facility that is a composite distinct part (as

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1VL211

Facility ID: 000146

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155242		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  09/28/2023	
	PROVIDER OR SUPPLIER		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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	admission agreem configuration, included that comprise the and must specify to room changes bet under §483.15(c)(Based on interview failed to notify the roblood sugars were configuration.	uding the various locations composite distinct part, the policies that apply to ween its different locations	F 0580	This Plan of Correction is the center's credible allegation of compliance.	10/18/2023
	9/26/23 at 10:00 a.n diabetes mellitus wit communication deficulties and survival mellitus with ketoacunspecified dement without behavioral of	ical record was reviewed on in. Diagnoses included type 2 ithout complications, cognitive icit, aphasia, dietary reillance, type 2 diabetes eidosis without coma, ia, unspecified severity, disturbance, psychotic disturbance, and anxiety.		Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s 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.	ot ment the
	a.m. daily, insulin g 22 units daily (7:00 lispro (treat high blo (7:00 a.m., 11:15 a.m. per sliding scale thr p.m. and 5:30 p.m.) than 60, call the phy greater than 500, ca (treat low blood sug for blood sugars les effects of hyperglyc medication use - ob effects: confusion, s	luded take blood sugar at 6:00 clargine (treat high blood sugar) a.m. to 11:00 a.m.), insulin bod sugar) 5 units before meals m. and 5:00 p.m.), insulin lispro ee time daily (8:00 a.m., 12:00 , if his blood sugar was less visicianif his blood sugar was ll the physician, Glucagon gar) 1 milligram (mg) as needed as than 60, and document side semic related to insulin serve him closely for side sweating, shortness of breath, ness, fatigue, increased thirst,		1) Immediate actions taken for those residents identified:  Resident L no longer resides at the facility. Resident M was assessed for any change of condition and MD reviewed the last 30 days of blood sugars.  2) How the facility identified of residents:	e e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155242	B. W	ING		09/28/	2023
NAME OF I	PROVIDER OR SUPPLIER	· }	-		ADDRESS, CITY, STATE, ZIP COD	_	
					WALNUT ST		
SIGNATI	URE HEALTHCARE	OF MUNCIE		MUNCI	E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	lethargy every shift	, shakiness, pale skin, and			A facility wide review of all		
	lemargy every sining	•			residents with a diagnosis of diabetes and with an order for	an	
	He had a current ca	re plan for a diagnosis of			has been reviewed to ensure		
	diabetes and he was at risk for unstable blood				have call parameters.	шоу	
	glucose as evidenced by hyperglycemia with						
	signs and symptoms of increased thirst,						
	1	vision, increased urination,					
		, blood sugars more than 180			3) Measures put into place/		
		leciliter) and hypoglycemia with			System changes:		
		s of shakiness, dizziness,					
	_	nunger, irritability, anxiety,			All licensed staff will be educa		
		consciousness, headache. He			related to, including but not lir	nited	
		luctuating blood sugars, 00's at times. He was a brittle			to, Notification of changes (injury/decline/room, etc.).		
		ninimal changes in insulin or			(injury/decline/room, etc.).		
		cation could cause significant					
		nd physician felt multiple					
		s as result of fluctuating blood			The DON/ADON/UM/SDC or		
	_	best intervention for him.			Clinical Consultant will audit the	he	
	Continue to monito	r him for glucose levels per			Facility Activity Report for any	,	
		26/23). Interventions included			blood sugar out of range to er	nsure	
	_	itoring as indicated (1/26/23),			proper documentation has be	en	
		th significant changes in signs			completed. This audit will be		
	and symptoms (1/2	6/23).			completed daily (M-F) X 8 we		
	Daviany of the alt:	cal record indicated on 8/8/23 at			Any identified concerns will be		
		l sugar was 49 mg/dl. His			immediately addressed with the responsible individual(s).	ie	
	· ·	units and his insulin lispro 5			responsible individual(s).		
	1	inistered. He was given two fig					
	bars.						
	On 8/8/23 at 10:12	a.m., his blood sugar was 109					
	mg/dl.						
	Th 10 1	111 4			A) 11		
	The clinical record lacked documentation of a physician notification of the low blood sugar.				4) How the corrective actions	WIII	
	pnysician notificati	on of the low blood sugar.			be monitored:		
	On 8/20/23 at 6:07	a.m. and 6:09 a.m., his blood					
	sugar was 41 mg/dl						

STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155242	B. W	ING		09/28/	2023
		ı		STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			WALNUT ST		
SIGNIATI	URE HEALTHCARE				E, IN 47303		
SIGNATI	ONE HEALTHUARD	_ OI IVIONOIE		WONCI	L, IIV 47 303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					After 8 weeks, to ensure		
	On 8/20/23 at 6:15 a.m., a notation was made in his MAR, his insulin lispro 5 units was not administered due to his blood sugar of 41 mg/dl.  On 8/20/23 at 10:56 a.m., his blood sugar was 175				continued compliance, the		
					DON/UM/ADON/SDC or Clini	cal	
					Consultant will continue to rev	/iew	
					the Facility Activity Report M-	F for	
					any blood sugar out of range	and	
	mg/dl.				to ensure proper documentati		
					was completed. Any identifie	ed	
		lacked documentation of a			concerns will be immediately		
		on or an intervention other			addressed with the responsib	le	
	than holding the insulin, to treat the low blood				individual(s).		
	sugar.						
		d 8/27/23 at 12:40 p.m.,					
		sugar was 38 mg/dl and PRN			The facility, through the QAPI		
	1 1	Gen (treat low blood sugar) was			program, will review, update,	and	
	administered per or	der.			make changes, as necessary	, to	
					this plan of correction to ensu	re	
		lacked documentation of a			substantial compliance for no	less	
	physician notificati	on of the low blood sugar.			than 6 months. The results of	f	
					these audits will be reviewed	in	
		d 8/27/23 at 12:55 p.m.,			Quality Assurance Meeting		
	•	vas given and his blood sugar			monthly for 6 months or until t	:he	
	_	walked around and ate lunch.			QA Committee determines		
	He had no signs or	symptoms of hypoglycemia.			compliance is achieved or if		
					ongoing monitoring is required		
		nical record was reviewed on			The QA Committee will identif	y	
		m. Diagnoses included type 2			any trends or patterns and ma		
		ith hyperglycemia, body mass			recommendations to revise th		
	` ′	4.9, and morbid (severe) obesity			plan of correction as indicated	l.	
	due to excess calor	ies.					
		cluded insulin lispro 10 units					
		:00 a.m., 11:15 a.m. and 5:00					
		ine 40 units daily (7:15 a.m. to					
		rmin (treat diabetes) 1,000 mg					
	twice daily, and document side effects of						
	hyperglycemic related to insulin medication use -						
	·	y for side effects: confusion,					
	sweating, shortness	of breath, fruity breath,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155242	B. W	ING	<u>.</u>	09/28	/2023
		ı		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			WALNUT ST		
SIGNATI	JRE HEALTHCARE	OF MUNCIE			E, IN 47303		
SIGNATO		_ OI WONOIL		WIGHT	L, IIV 47 303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	increased thirst, increased					
	urination, shakiness	s, pale skin, and lethargy every					
	shift.						
	He had a current care plan for a diagnosis of						
		s at risk for unstable blood					
	_	ed by hyperglycemia with					
		s of increased thirst,					
		vision, increased urination,					
	1	s, blood sugars more than 180					
	, , , , , ,	cemia with signs and					
	1 * *	ness, dizziness, sweating,					
		tability, anxiety, decreased					
		ess, headache. He had started					
	_	, the reason was unknown. The					
		e aware of the refusals. A					
	_	referral, continued non					
		et restrictions (8/2/23). His					
		ded blood glucose monitoring					
		3) and notify physician with					
	1 -	in signs and symptoms					
	(8/2/23).						
							1
		a.m., his blood sugar was					
	documented as "hig	gh".					
		lacked physician notification					
	for the high blood s	sugar.					
	0.0/5.22						
		a.m., his blood sugar was					
	documented as "hig	gh".					
		lacked physician notification					
	for the high blood s	sugar.					
	D	'4 I DN 7 0/07/02 + 2.55					1
	_	w with LPN 7, on 9/27/23 at 3:55					
		she would call the doctor if a					
		ar was out of parameters, she					
	_	note in and recheck the					
	resident's blood sug	gar.	ı				1

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155242	A. BU B. WI	ILDING	00	COMPL 09/28/	
		155242	D. WI			09/20/	2023
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD WALNUT ST		
SIGNATU	JRE HEALTHCARE	OF MUNCIE			E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
F 0600 SS=D Bldg. 00	During an interview with the Social Serv 9/28/23 at 1:49 p.m blood sugars were be would call the phys staff should put a melood sugar. If the beparameters they we and a snack.  During an interview p.m., she indicated parameters she wou recommendations, precheck the blood staff. "Notification of Chaby the Administrate indicated the follow facility mustconsuphysicianwhen the treatment significan notification or notification or notification or notification"  This Federal tag rel 3.1-5(a)(3)  483.12(a)(1) Free from Abuse as	with the LPN/Unit Manager, vice Director present, on, she indicated if a resident's below or above parameters she ician for any new orders. The burses note in and recheck the blood sugar was below re allowed to give orange juice with RN 29, on 9/28/23 at 2:44 if the blood sugars were out of ald call the physician for but in a nurses note and ugar.  Cacility policy, titled ange of Condition," provided or, on 9/27/23 at 3:02 p.m., ving: "Guidelines: 1. The bult with the residents' ere isc. A need to alter atly2. Documentation of action attempts should be dents electronic medical attes to complaint IN00418061.					
	abuse, neglect, m property, and expl	the right to be free from isappropriation of resident loitation as defined in this udes but is not limited to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155242	B. W	ING		09/28	/2023
NAME OF P	DOMDED OF CURRY TER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>c</u>		4301 N	WALNUT ST		
SIGNATU	JRE HEALTHCARE	OF MUNCIE		MUNCI	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 APPROPRIA DEFICIENCY)	√TE	COMPLETION
TAG	freedom from corp	R LSC IDENTIFYING INFORMATION	+	TAG	DELICE!		DATE
	·	•					
	involuntary seclusion and any physical or chemical restraint not required to treat the						
	resident's medical						
		, .					
	§483.12(a) The fa	cility must-					
	§483.12(a)(1) Not	use verbal, mental, sexual,					
		, corporal punishment, or					
	involuntary seclus						10/12/202
		ons, interviews, and record	F 00	600	ol class="NumberListStyle1		10/18/2023
	-	failed to protect the resident's 1 verbal abuse by CNA 4 for 1			SCXW251428091 BCX0"		
	-	wed for abuse (Resident B and			role="list" start="1" style="mar 0px; padding: 0px; user-selec	-	
	CNA 4).	wed for abuse (Resident B and			text; -webkit-user-drag: none;		
	CIVIL 1).				-webkit-tap-highlight-color:		
	Findings include:				transparent; overflow: visible;		
	C				cursor: text;"		
	On 9/26/23 at 3:09	p.m., Resident B was observed			1) Resident B has been asses	sed	
	-	r walker in the hallway. She			for any changes with mental		
		nice to her and they better be.			status, anguish, or distress. T		
		en mean to her and she			allegation Resident B discuss		
		h it, she paid the bill at the			with the surveyor had already	been	
	facility.				reported to IDOH with the	ooro	
	On 9/28/23 at 4·02 :	p.m., Resident B was observed			investigation completed. The plan has been updated to refle		
		r walker in the hallway.			the of the . An investigation w		
		···y -			completed on CNA 4. CNA 4		
	Resident B's clinica	l record was reviewed on			re-educated on abuse and		
	9/26/23 at 11:45 a.r	n. Diagnoses included major			customer service. RN 25 was	;	
	-	, recurrent, Alzheimer's			re-educated on who to report	any	
	_	dementia, unspecified			type of abuse to.		
	•	chavioral disturbance,					
		ce, mood disturbance, and					
	anxiety.				0) A ama timas		
	A quarterly Minimy	um Data Sat (MDS)			2) A one-time resident intervie		
	A quarterly Minimum Data Set (MDS) assessment, dated 7/5/23, indicated she was				process has been completed		
		the Brief Interview for Mental			the current population, completed on 9/26/23, with no other issues		
	Status (BIMS).	and Differ interview for Michigan			identified during the	03	
	()-		1		1		I

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Event ID:

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Facility ID: 000146

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155242	B. WI	NG		09/28/	2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	2			WALNUT ST		
CICNIATI		OF MUNICIE					
SIGNATO	JRE HEALTHCARE	OF MUNCIE		MONCII	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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					interview/resident assessment		
	She had a current ca	are plan for being at risk for			process. An Ad Hoc QAPI		
	change in mood star	te, she report a stakeholder hit			meeting was held on 9/27/23 v	vith	
	-	her arm while conversing with			the Medical Director and QAP		
	-	Upon investigation, she			Team. The facility staff have b		
		in her right wrist and arm on			re-educated on abuse prohibit		
		in to blood draw on 8/4/23. In			to include verbal abuse.	,	
		oted to be instructing another					
		way the other resident didn't					
		Aide was in hallway, and did					
	-	he other resident does live on					
	-	then made negative comment					
		ess statements do not support			ol class="NumberListStyle1		
		Resident had potential verbal			SCXW251428091 BCX0"		
		f member. Resident does not			role="list" start="3" style="mar	ain:	
		re statements regarding aide,			Opx; padding: Opx; user-select	_	
		t did not hear negative			text; -webkit-user-drag: none;	-	
		t loud. Resident has not			-webkit-tap-highlight-color:		
		ersation related to possible			transparent; overflow: visible;		
		by aide. No change in mental			cursor: text;"		
	-	at present (8/19/23). Her			3) It is the responsibility of the		
		led encourage and allow open			facility staff to uphold the abus	e	
		ng(8/19/23), observe			prohibition policy and procedu		
	-	ffects of medications as			and to refrain from swearing a		
		provide regular opportunities			yelling while working in the		
		y, daily decision making,			facility. The Director of Nursin	a.	
		zation, leisure activities			Assistant Director of Nursing,	-	
		rests (8/19/23), report to			Manager, Shift Supervisor, Cli		
		n mood status (8/19/23) and			Consultant, and/or the		
		rengths and coping skills			Administrator will be responsib	ole	
	(8/19/23).	9 F 9 mmp			to interview staff on abuse		
	( <del></del> )-				prohibition, including if there ha	ad	
	A nurses note, dated	d 9/16/23 at 2:25 p.m.,			been any situation not reported		
		eakfast tray pass, Resident B			immediately to the Abuse	<b>-</b>	
	_				Coordinator 3 times a week for	r (4)	
	saw the cart in the hallway and began to worry about her breakfast getting cold. She walked back				four weeks, two times weekly t	. ,	
	about her breakfast getting cold. She walked back and forth in the hallway until she found CNA 4,				(4) four weeks; weekly for (4) f		
	who was working that hall. She began following		weeks; then monthly for three				
	CNA 4 and talking about the fact she wanted her				months. Any issues identified	will	
		e it was hot. CNA 4 continued			be immediately corrected, 1:1	VVIII	
	oreakiast now willing	on was not. Civil 4 continued			be miniediately confected, 1.1		

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Event ID:

1VL211 Facility ID: 000146

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/28/2023 155242 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4301 N WALNUT ST SIGNATURE HEALTHCARE OF MUNCIE MUNCIE. IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE with her passing order. Resident B became re-education completed for aggressive with her tone and continued to follow stakeholder as identified, up to her room to room. CNA 4 said out loud "Ok, I will and including disciplinary action make sure you get your tray last you mean old as determined necessary by the woman." There was no response or reaction from Administrator and Director of Resident B. The shift supervisor, DON, family and Nursing. physician were informed. The facility investigation was reviewed on 9/26/23 at 10:55 a.m. and indicated the following: 4) The Administrator will review the audits completed on a weekly basis. Results of the reviews will A hand written statement by CNA 4, dated be forwarded to the Quality 9/16/23, indicated Resident B chased down the Assurance Performance hall demanding he tray first. Resident B was in her Improvement Committee monthly face yelling at her. As Resident B walked away for 3 months, and then quarterly CNA 4 said under her breath, she could just make for 3 quarters. Based on sure she got her tray last. As soon as she said it, evaluation of audits and she regretted it and got Resident B's tray first and observations, the QAPI Committee took it straight into her room. determined the facility is in substantial compliance on A handwritten statement by RN 25, dated 9/16/23, 10/10/23. Audit documentation indicated CNA 4 was passing trays on the 300 will continue to be submitted to hall. Resident B was upset about cold food and the QAPI committee for review and she wanted her tray. She was aggressive in her to ensure compliance goals. speech and continue to follow CNA 4 as she QAPI committee reserves the right passed trays. CNA 4 said out loud "Ok, I will make to modify or extend monitoring sure you are last one to get your tray, you mean times according to outcomes. old woman." Resident B had no reaction. The Administrator is responsible for the oversight of this plan to During an interview with CNA 4, on 9/26/23 at ensure ongoing compliance. 11:36 a.m., she indicated lunch trays were being served. Resident B was chasing her down the hall, yelling and spitting on her. They were running behind and her tray was the last on one on the cart. She wanted her tray. It was her first time working on that hall. She did not call her a mean old woman. She was provided with education on verbal abuse, all the types of abuses and suspended for three days.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155242		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COM	re survey ipleted 28/2023			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 4301 N WALNUT ST MUNCIE, 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	p.m., she indicated 4 around wanting h Resident B. RN 25 CNA 4 was coming right behind her. CN sure you get served CNA 4 could had a things being said if the tray. She reporte supervisor.  A 9/15/23 revised f Neglect and Misapp provided by the Adp.m., indicated the roganization's inten of abuseVerbal A written or gestured threat, or any fright derogatory languag or within their hear ability to comprehe	acility policy, titled "Abuse, propriation of Property," ministrator on 9/27/23 at 3:02 following: "It is the tion to prevent the occurrence buse is the use of any oral, language that includes any ening, disparaging or e, to residents or their families, ng distance, regardless of age,						
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(Reporting of Alleg §483.12(c) In respanse, neglect, exthe facility must:  §483.12(c)(1) Ensitions involving exploitation or misinjuries of unknow	ed Violations conse to allegations of cploitation, or mistreatment, ure that all alleged g abuse, neglect, treatment, including						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155242	B. W	ING		09/28/	/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4301 N WALNUT ST MUNCIE, IN 47303				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID	NEOVIDERIC N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	reported immediated hours after the allegevents that cause or result in serious than 24 hours if the allegation do not in result in serious be administrator of the officials (including Agency and adult state law provides care facilities) in a through established \$483.12(c)(4) Reginvestigations to the designated region of the designated region of the sum of the facility abuse were reported for 3 of 7 residents (Resident L and CN and Resident F and Findings include:  Confidential intervithe course of the sum of her face, she work of the sum of the face, she work of the face, she work of the sum of the face, she work of the face, she	tely, but not later than 2 egation is made, if the the allegation involve abuse is bodily injury, or not later ee events that cause the involve abuse and do not odily injury, to the e facility and to other to the State Survey protective services where if or jurisdiction in long-term iccordance with State law ed procedures.  For the results of all the administrator or his or presentative and to other ance with State law, ate Survey Agency, within the incident, and if the es verified appropriate must be taken. In, interview, and record failed to ensure allegations of to the State Agency timely reviewed for abuse allegations IA 6, Resident K and CNA 6 CNA 13.)	F 00	609	ol class="NumberListStyle1 SCXW22017365 BCX0" role= start="1" style="margin: 0px; padding: 0px; user-select: text- webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 1) Resident L was assessed b the Social Services Director at Director of Nursing upon report the negative statements. The were no signs of a change in mental status, free of signs or symptoms of mental anguish of distress. There were no visibl changes to resident appearan skin. The care plan has been	t; oy nd rt of re or e ce or	10/18/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155242	B. WI	NG		09/28/	2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			WALNUT ST		
SIGNATI	URE HEALTHCAR	E OF MUNCIE			E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
1710		NA 6's mom. CNA 6 told		1710	updated to reflect the of the .	Thie	DATE
	_	one talked about her mom and			incident was reported to ISDH		
	if she did she was going to go to jail. Resident K had anxiety and with CNA 6 telling her she was going to go to jail caused her more anxiety and				incident was reported to IODI	1.	
					2) Resident K was assessed	with	
		nd got worked up. They were			no negative findings. When	With	
		gns of abuse through			interviewed, Resident K had r	10	
		port. The incidents were			recollection of the incident an		
		ed to the DON and she had the			denied having any concerns v	1	
	staff make out state				any staff members. Resident		
					was assessed by the Social		
	During a confident	ial interview, it was indicated			Services Director with no neg	ative	
		comb Resident L's hair. Resident			findings. There were no visib		
	L had a knot in her	hair that needed worked on.			changes to resident appearar		
	Resident L was up	set and didn't want her hair			skin. The care plan has been		
	combed. She kept	telling CNA 6 to get out of her			updated to reflect the of the .		
	face and get away	from her. CNA 6 was not			incident was reported to ISDF	<del>1</del> .	
	reading Resident L	's body language and that she			CNA 6 is no longer employed	by	
	was upset. CNA 6	needed to reapproach Resident			Signature Healthcare.		
	L at a later time, it	was reported to the DON and					
	she had the staff m	ake out statements.					
					ol class="NumberListStyle1		
	_	w with the DON, on 9/27/23 at			SCXW22017365 BCX0" role=	-"list"	
	· ·	icated when she asked the			start="2" style="margin: 0px;		
		idents with CNA 6, she			padding: 0px; user-select: tex	it;	
		e didn't feel like it was abuse.			-webkit-user-drag: none;		
		statements were made out, but			-webkit-tap-highlight-color:		
	she would look.				transparent; overflow: visible;		
	D	'4 D '1 (E 0/07/03 )			cursor: text;"		
	_	w with Resident F, on 9/26/23 at			0.4 4:		
	· ·	icated she sat near a resident in			3) A one-time resident interview		
	_	s a fall risk. She watched the			process has been completed		
		ff because she liked to get up risk. She had told an			the current population, compl		
					on 9/26/23, with no other issu	es	
	unidentified CNA, the resident was getting up and the CNA told her to "shut up". This happened				identified during the interview/resident assessmen	, t	
					process. An Ad Hoc QAPI	JL .	
	about a month ago, she did not report it right away, but reported it to the DON about three				meeting was held on 9/27/23	with	
	weeks ago. She was offended by her telling her to				the Medical Director and QAF		
	_	ot how people were supposed			Team. The facility staff have		
	I shar ap, that was if	or non people were supposed	1		I really stall liave	20011	

		X1) PROVIDER/SUPPLIER/CLIA	ì í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			UILDING	00	COMPLETED		
		155242	B. W	/ING		09/28/2	2023
NAME OF F	PROVIDER OR SUPPLIER	· {	•		ADDRESS, CITY, STATE, ZIP COD		
					WALNUT ST		
SIGNAT	JRE HEALTHCARE	: OF MUNCIE		MUNCI	E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	T	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION othing was done about it and	+	TAG		tion	DATE
		_		re-educated on abuse prohibition, to include verbal abuse.			
	the CNA still worked at the facility. She didn't know the CNA's name, but she could recognize						
	her.	,					
	_	w with the DON, on 9/26/23 at					
	_	icated she was not aware of the			4) It is the responsibility of the		
		ent F. The DON approached			facility staff to uphold the abus		
		sident F explained the incident dicated she honestly did not			prohibition policy and procedu		
		rting the incident to her and she			and to refrain from swearing a yelling while working in the	ıııu	
	would take care of	9			facility. The Director of Nursir	na	
					Assistant Director of Nursing,	•	
	Resident F's clinica	l record was reviewed on			Manager, Shift Supervisor, Cl		
	9/26/23 at 3:14 p.m	. Diagnoses included other			Consultant, and/or the		
		e, episodes, generalized			Administrator will be responsi	ble	
	-	d cognitive communication			to interview staff on abuse		
	deficit.				prohibition, including if there h		
		cluded buspirone (treat anxiety)			been any situation not reporte	:d	
	-	laily, and desvenlafaxine ression) 100 mg daily.		immediately to the Abuse			
	succinate (treat dep	ression) 100 mg dany.			Coordinator 3 times a week for four weeks, two times weekly		
	A quarterly MDS, o	dated 8/11/23, indicated she			(4) four weeks; weekly for (4)		
	was cognitively inta				weeks; then monthly for three		
					months. Any issues identified	will	
		a.m., Resident L was observed			be immediately corrected, 1:1		
	in bed. She indicate	ed everyone was nice to her.			re-education completed for		
	Pagidant I la aliai	I was and trian nations of an			stakeholder as identified, up to		
		l record was reviewed on  Diagnoses cognitive			and including disciplinary action as determined necessary by t		
	_	icit, unspecified dementia,			Administrator and Director of	116	
		y, without behavioral			Nursing.		
		otic disturbance, mood					
	disturbance, and an						
		cluded escitalopram oxalate					
	(treat anxiety) 10 m	ng (mg) daily.			: 1		
	A 6/2/22 assautantanta	MDS indicated she was			p paraid="663717715"	6 010	
		MDS indicated she was  No behaviors were exhibited.			paraeid="{f396b5d4-b6be-411	0-913	
l	Loginuvery miact. I	NO DEHAVIOIS WEIE EXHIBITEU.	1		e-74c1013a0700}{158}" >		

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Event ID:

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Facility ID: 000146

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PRINTED: 10/24/2023

	T OF HEALTH AND HU R MEDICARE & MEDIC					MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155242  NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MUNCIE		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION IG <u>00</u>	COM	(X3) DATE SURVEY COMPLETED 09/28/2023	
		430	EET ADDRESS, CITY, STATE, ZIP O D1 N WALNUT ST INCIE, IN 47303	COD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	of treatment or care care, medications, prushing hair (revisinterventions included termine why she her during care to enducate her regardite treatment to her her member address her care (7/5/22) and prushing for the care (7/5/22).  Her clinical recordincident with CNA On 9/27/23 at 9:49 sitting on the side of everyone was nice.  Resident K's clinical recordination of the side of everyone was nice.  Resident K's clinical recordination of the side of everyone was nice.  Her medication definition of the side of the severity, without be psychotic disturbarian anxiety.  Her medications in milligram daily and milligram daily	a.m., Resident K was observed of her bed. She indicated to her.  al record was reviewed on n. Diagnoses included cognitive ficit, generalized anxiety ed dementia, unspecified ehavioral disturbance, and cluded escitalopram oxalate 20 d trazodone (treat depression) 50 y Minimum Data Set (MDS), severely cognitively impaired. exhibited.		The Administrator will audits completed on a basis. Results of the results of a months, and there for 3 quarters. Based evaluation of audits are observations, the QAF determined the facility substantial compliance 10/18/23. Audit docur will continue to be subthe QAPI committee for to ensure compliance QAPI committee resert to modify or extend modify or extend modified the oversight of this ensure ongoing complete.	weekly reviews will uality ce tee monthly n quarterly on nd PI Committee is in e on mentation mitted to or review and goals. ves the right onitoring comes. esponsible s plan to	
	Her clinical record	lacked documentation of the				

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incident with CNA 6.

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PRINTED: 10/24/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155242			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMPI	(X3) DATE SURVEY COMPLETED 09/28/2023	
	PROVIDER OR SUPPLIEI		4301 N	ADDRESS, CITY, STATE, ZIP CO WALNUT ST E, IN 47303	DD		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 0610	Neglect and Misapp provided by the Adp.m., indicated the the use of any oral, that includes any the disparaging or dero or their families, or regardless of age, a disabilityAllegati report, complaint, gor other facts that a understand to mean policy, is occurring might have occurre be reported to the Stime the allegation 3.1-28(c)						
SS=D Bldg. 00	§483.12(c) In response abuse, neglect, exthe facility must:  §483.12(c)(2) Haviolations are thore §483.12(c)(3) Preneglect, exploitation in the investigation in the investigations to the designated reofficials in accord	nt/Correct Alleged Violation conse to allegations of exploitation, or mistreatment, we evidence that all alleged roughly investigated.  Event further potential abuse, on, or mistreatment while in progress.  Foort the results of all the administrator or his or presentative and to other ance with State law, tate Survey Agency, within					

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5 working days of the incident, and if the alleged violation is verified appropriate

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
155242		155242	B. W	ING		09/28/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			WALNUT ST		
SIGNATI	JRE HEALTHCARE	OF MUNCIE			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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	corrective action r						
		on, interview, and record	F 0	610	ol class="NumberListStyle1		10/18/2023
		failed to ensure allegations of			SCXW250548321 BCX0"		
	_	ated for 3 of 7 residents			role="list" start="1" style="mar	-	
		allegations (Resident L and			0px; padding: 0px; user-select	t:	
		and CNA 6 and Resident F			text; -webkit-user-drag: none;		
	and CNA 13).				-webkit-tap-highlight-color:		
	E' 1' ' 1 1				transparent; overflow: visible;		
	Findings include:				cursor: text;"		
	Confidential int	arria rriana a andriata di danda a			What corrective action will be		
		ews were conducted during			accomplished for those reside		
	the course of the su	rvey.			found to have been affected b	y tne	
	During a confidential interview, it was indicated				alleged deficient practice?		
	_	t CNA 6 to get out of her face			Resident L was assessed	al	
	-	vant her hair brushed. CNA 6			physically and for psychosocial The MD was updated, and the		
		en someone told her to get out			incident was reported to ISDH		
		n't, because no one would talk			I incident was reported to ISBN	١٠.	
		t same day, Resident K said			Resident K was interviewed w	<sub>iith</sub>	
		NA 6's mom. CNA 6 told			no recollection of the incident.		
		one talked about her mom and			Resident K was asked if she h		
		oing to go to jail. Resident K			any concerns with any staff	iuu	
		h CNA 6 telling her she was			members which she no.		
	-	aused her more anxiety and					
		d got worked up. They were			Resident F was assessed		
	taught about the sig				physically and for psychosocia	al.	
	-	port. The incidents were			The MD was updated, and the		
	_	ed to the DON and she had the			incident was reported to ISDH		
	staff make out state				·		
	During a confidenti	al interview, it was indicated			p paraid="905030467"		
	_	omb Resident L's hair. Resident			paraeid="{f8c357f3-429c-4d72	<sub>2-b3c</sub>	
		hair that needed worked on.			e-40f64d3e7d38}{68}" >CNA		
		et and didn't want her hair			longer is employed with Signa		
	_	elling CNA 6 to get out of her			Healthcare.		
	_	rom her. CNA 6 was not					
		s body language and that she					
	_	needed to reapproach Resident			How be identified and what		
	_	was reported to the DON and			corrective action will be taken	?	
	she had the staff ma	-					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155242	B. WI	NG		09/28	/2023
			I	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			WALNUT ST		
SIGNIATI	JRE HEALTHCARE	OF MUNCIE			E, IN 47303		
SIGNATO	UNE REALITUARE			WONCH	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	w with the DON, on 9/27/23 at			·All residents have the poter	ıtial	
		cated when she asked the			to be affected; therefore, a fac	ility	
		dents with CNA 6, she			wide questionnaire regarding		
	indicated to her she	didn't feel like it was abuse.			abuse was completed on		
		tatements were made out, but			9/27/2023 with all residents wi		
	she would look.				BIMS of 8 or greater to ensure	<del>!</del>	
					proper documentation was		
	_	w with Resident F, on 9/26/23 at			completed and if an investigat		
	,	cated she sat near a resident in			was warranted. The nurse's n		
	_	a fall risk. She watched the			were reviewed from 9/1/2023 -	_	
		f because she liked to get up			9/30/2023 to review for any		
	and she was a fall r				documentation that may warra		
		the resident was getting up and			an investigation. The IDT tear		
		"shut up". This happened			has been re-educated on wha		
		she did not report it right			report to ISDH and the timefra	me	
		it to the DON about three			for reporting.		
	_	s offended by her telling her to					
	_	ot how people were supposed			What measures will be put into	)	
		othing was done about it and			place and what systematic		
		ed at the facility. She didn't			changes will be made to ensu		
		me, but she could recognize			that the deficient practice does	s not	
	her.				recur?		
		11 1 701 0/06/00					
	_	w with the DON, on 9/26/23 at					
	_	icated she was not aware of the			Beginning 10/13/2023, the		
		ent F. The DON approached			DON/ADON/Unit		
		sident F explained the incident			Managers/SDC/TCN or Clinica		
		dicated she honestly did not			Consultant will review the Fac	-	
		rting the incident to her and she			Activity Report for documented	1	
	would take care of	ιι.			notes that may warrant an	امدا	
	Dagidant Els -1:	Leanard was estimated an			investigation. The DON or Clir		
		l record was reviewed on			Consultant will review all incident		
	_	. Diagnoses included other e, episodes, generalized			to ensure corrective actions w		
		d cognitive communication			completed and reported to ISE		
	=	a cognitive communication			This audit will be reviewed M-I	-	
	deficit.	aludad hugnirana (traat anviets)			weeks.		
		cluded buspirone (treat anxiety)					
		laily, and desvenlafaxine					
	succinate (treat dep	ression) 100 mg daily.	1		p paraid="755340880"		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLETED	
		155242	B. W.	ING		09/28/	2023
NAME OF I	PROVIDER OR SUPPLIER	•	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
				1	WALNUT ST		
SIGNATI	JRE HEALTHCARE	OF MUNCIE		MUNCI	E, IN 47303		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A manufact AMDC	1-4-10/11/22 :1: 4 1 1			paraeid="{f8c357f3-429c-4d7	2-b3c	
		dated 8/11/23, indicated she			e-40f64d3e7d38}{114}" >		
	was cognitively into	act.					
	On 9/27/23 at 9:49 a.m., Resident L was observed				How be monitored to ensure	the	
		ed everyone was nice to her.			deficient practice will not recu		
		-			what quality assurance progra		
	Resident L's clinica	l record was reviewed on			will be put into place?		
	9/27/23 at 4:15 p.m	. Diagnoses cognitive					
	communication deficit, unspecified dementia,						
		y, without behavioral			·After 8 weeks, the		
disturbance, psychotic disturbance, mood					DON/ADON/Unit		
	disturbance, and an	xiety.			Managers/SDC/TCN or Clinic		
					Consultant will continue to re		
		cluded escitalopram oxalate			the Facility Activity Report for	any	
	(treat anxiety) 10 m	ng (mg) daily.			documented note that may	,	
	Δ 6/3/23 quarterly	MDS indicated she was			warrant an investigation daily M-F. Any discrepancies foun		
		No behaviors were exhibited.			be reported to the Regional N		
	Jogintively intact. I	to deliavious were camoriou.			Consultant or VP of Operation		
	She had a current b	ehavioral care plan for refusal			Results of the audit will be		
		e. As example by, refusal of			reported to the QA committee	.	
		getting out bed, showers and			weekly to determine the furth		
	_	sed on 9/18/23). Her			need of continued education		
		led converse with her to			revision of plan. At that time,		
		refused (3/6/23), converse with			based on evaluation, the QA		
	_	xplain procedure (7/5/22),			committee will determine at w		
		ng the importance of care and			frequency the audit of control		
		alth (7/5/22), have another staff			substances by management	will	
		r (7/5/22), offer another time for			need to continue. Concerns		
		rovide positive reinforcement			identified will be corrected		
	(7/5/22).				immediately and reported to t		
	How aliminations 1	la alrad da assessantation of the			ensure investigation of prope	-	
	incident with CNA	lacked documentation of the			counting controlled substance	es	
	incident With CNA	υ.			audits are being conducted.		
	On 9/27/23 at 9:49	a.m., Resident K was observed					
		of her bed. She indicated					
	everyone was nice						
					A QAPI meeting was held on		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/28/2023 155242 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4301 N WALNUT ST SIGNATURE HEALTHCARE OF MUNCIE MUNCIE, IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Resident K's clinical record was reviewed on 9/27/2023 with the QAPI 9/27/23 at 3:56 p.m. Diagnoses included cognitive committee. Beginning the week of communication deficit, generalized anxiety 10/2/2023, the QAPI committee disorder, unspecified dementia, unspecified will meet monthly throughout the severity, without behavioral disturbance, audit for recommendations and psychotic disturbance, mood disturbance, and further follow up regarding the anxiety. above stated plan. The audit documentation will continue to be Her medications included escitalopram oxalate 20 submitted to the monthly QAPI milligram daily and trazodone (treat depression) 50 committee for review and to mg daily. ensure ongoing compliance. The QAPI committee reserves the right A 8/15/23 quarterly Minimum Data Set (MDS), to modify or extend monitoring indicated she was severely cognitively impaired. times according to outcomes. No behaviors were exhibited. The Administrator is responsible for the oversight of this plan to Her clinical record lacked documentation of the ensure ongoing compliance. incident with CNA 6. A 9/15/23 revised facility policy, titled "Abuse, Neglect and Misappropriation of Property," provided by the Administrator on 9/27/23 at 3:02 p.m., indicated the following: "...Verbal Abuse is the use of any oral, written or gestured language that includes any threat, or any frightening, disparaging or derogatory language, to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability...Allegation of Abuse: This means a report, complaint, grievance, statement, incident or other facts that a reasonable person would understand to mean that abuse, as defined in this policy, is occurring, has occurred, or plausibly might have occurred...E. Investigation Guidelines 1. The Facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute "allegations of abuse,"...The Facility Administrator may delegate some or all of the investigation as appropriate, but the Facility Administrator retains the ultimate

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Event ID:

1VL211

Facility ID: 000146

If continuation sheet

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

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00			COMPLETED	
		155242	B. WI	NG		09/28/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER			4301 N WALNUT ST					
SIGNATURE HEALTHCARE OF MUNCIE				MUNCIE, IN 47303				
(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 APPROPRIA	TF	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	responsibility to over	ersee and complete the						
	investigation, and to draw conclusions regarding							
	the nature of the inc	eident"						
	3.1-28(d)							

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