STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155242	A. BUILDING 00 B. WING	08/29/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00442103, IN00441172, and IN00440421. Complaint IN00442103 - Federal/state deficiencies related to the allegations are cited at F656. Complaint IN00441172 - No deficiencies related to the allegations are cited. Complaint IN00440421 - No deficiencies related to the allegations are cited. Survey dates: August 27, 28, & 29, 2024 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 130 Total: 130 Census Payor Type: Medicare: 4 Medicaid: 103 Other: 23 Total: 130 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 3, 2024.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility	F 0656	Resident K's care plan was	09/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	failed to develop a resident-centered careplan and interventions to address a resident's use of alcohol and physical aggressive behaviors. (Resident K) Findings include: The clinical record for Resident K was reviewed on 8/29/24 at 9:34 a.m. Diagnoses included history of pulmonary embolism, history of other venous thrombosis and embolism, fracture of neck of right femur, pressure ulcer of sacral region, osteomyelitis, acute kidney failure, polyneuropathy, chronic stage 3 kidney disease, opioid use, chronic congestive heart failure, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, gastro-esophageal reflux disease, anemia, hyperkalemia, and vitamin D deficiency. The most recent annual Minimum Data Set (MDS) assessment, dated 7/30/24 indicated Resident K was cognitively intact. Review of the clinical record indicated a lack of a care plan and interventions to address Resident K's alcohol consumption and physical aggression. A progress note, dated 08/19/24 at 3:59 p.m., indicated Resident K had been involved in a physical altercation with another resident off facility property. Resident K returned to the facility, with slurred speech, cursing and screaming. The resident became physically aggressive with staff by punching, choking and grabbing them. 911 was called and the resident was sedated before being removed from the facility. The resident returned to the facility from the hospital, sober, on 8/19/24 at 4:00 a.m.		updated to include alcohol usage and physical aggressive behaviors. All other residents who exhibit physical aggressive behaviors or consume alcohol were reviewed to ensure that each had a resident-centered care plan with interventions. The interdisciplinary team will be in serviced on the policy "Comprehensive Care plans" by the DON or designee regarding resident-centered care plan and intervention development. The Unit Manager, or designee, will complete audits on new residents, as available, that have physical aggressive behaviors, consume alcohol, or pertinent diagnoses to ensure care plan accuracy. Audits will occur weekly x4 weeks, every other week x2 months, then monthly x3 months. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes.	

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	During an interview, on 8/28/24 at 11:10 a.m., RN 1 indicated, on 8/18/24 at approximately 7:22 p.m., she observed Resident K getting into an physical altercation with another resident. The residents were off facility property, smoking and drinking alcohol. This (smoking and drinking) was not a new behavior for this resident. RN 1 intervened and assisted the residents back into the facility. When Resident K got back into the facility, he "went after" RN 2, demanding his pain medication. RN 2 was on the telephone with a physician. RN 1 verbalized to Resident K he should not take narcotics if he has been drinking. Resident K backed RN 1 against the wall. LPN 3 arrived and took the resident to the front lobby area. The resident remained aggressive and staff had to call the police. At one point, the resident started hitting RN 3. RN 1 pulled the resident's wheelchair back to get him away from LPN 3. The resident then grabbed the front of RN 1's uniform top and started twisting it around her neck. RN 1 indicated it took four to five staff members to get him to let go. LPN 3 called the police. When the police arrived, Resident K became aggressive with them and had to be handcuffed to his wheelchair. Resident K was taken to a local hospital by ambulance. During an interview on 8/28/24 at 11:40 a.m., LPN 3 indicated when she got to Resident K, after he returned to the facility, the resident as sitting in the doorway of his room. The resident began swinging a wheelchair pedal at her. She was able to get behind the resident and pushed his wheelchair to the front of the building. She had known the police were on the way. Resident K had a history of being verbally aggressive towards others, but she had not seen him being physically aggressive before. The resident also had a history of smoking and drinking off facility			

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	property. Review of a security video (no audio) with the Administrator on 8/28/24 at 2:57 p.m., dated 8/18/24 from 7:30 p.m. to 8:10 p.m., showed Resident K sitting in his wheelchair in the front lobby of the facility. LPN 3 was with the resident. Resident K was observed making sporadic movements in the wheelchair, pushing it back and forth and backing into the wall. LPN 3 was observed approaching the resident slowly. The resident became more agitated and started swinging and grabbing at LPN 3. RN 1 arrived and got behind the wheelchair to pull the resident away from LPN 3. The resident reached above and behind his head and grabbed the front of RN 1's shirt and started twisting it around her neck. Several staff member arrived and assisted RN 1 and LPN 3. When the police arrived, the resident became physically aggressive toward them. The police were observed putting the resident's hands behind the wheelchair and using handcuffs to secure the resident. During an interview on 8/29/24 at 9:39 a.m., LPN 4 indicated Resident K could be verbally aggressive, but staff were usually able to calm the resident down. LPN 4 had never seen the resident be physically aggressive towards anyone. She indicated there should have been an event documented for new or worsening behaviors. The clinical record was reviewed with the DON present. The clinical record lacked an event for new or worsening behaviors. A current policy, dated 4/6/15, titled, "Comprehensive Care Plans," was provided by the Corporate Clinical Support on 8/29/24 at 11:00 a.m. The policy indicated the following: "...Policy Statement			

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	The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. GUIDELINE: .... 4. Each resident's Comprehensive Care plan [sic] is is designed to: a. Incorporate identified problem areas. b. Incorporate risk factors associated with identified problems. c. Revised as necessary with changes... 5. The Comprehensive Care Plan may assist in preventing or reducing declines that are not unavoidable, in the resident's physical and psychosocial needs. 6. The Comprehensive Care Plan will be person-centered for each resident...." This citation relates to complaint IN00442103. 3.1-35(d)(1)			