PRINTED: 07/09/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155242	B. WING			l	C <b>/03/2025</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST		<u>  077</u>	03/2023
				М	UNCIE, IN 47303		I
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	•	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F 000	INITIAL COMMENTS		F	000			
		Investigation of Complaints 1690 and IN00460801.					
	Complaint IN0046186 deficiencies related to F609, F610, and F75	the allegations are cited at					
	Complaint IN0046169 to the allegation are o	00 - No deficiencies related sited.					
	Complaint IN0046080 to the allegation are c	01 - No deficiencies related sited.					
	Survey dates: July 1,	, 2, and 3, 2025					
	Facility number: 000 Provider number: 15: AIM number: 100291	5242					
	Census Bed Type: SNF/NF: 120 Total: 120						
	Census Payor Type: Medicare: 5 Medicaid: 97 Other: 18 Total: 120						
	These deficiencies re accordance with 410	flect State Findings cited in IAC 16.2-3.1.					
F 609 SS=D		Violations	F	609			
	§483.12(c) In respons	se to allegations of abuse,					
APODATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	=		TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MUNCIE  (XA) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 609  Continued From page 1 neglect, exploitation, or mistreatment, the facility must:  \$483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. To the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MUNCIE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 609  Continued From page 1 neglect, exploitation, or mistreatment, the facility must:  \$483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation of resident property, are reported immediately, but not later than 2 hours after the allegation involve abuse and do not result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, or officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established			155242	B. WING _					
F 609  Continued From page 1 neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established			JNCIE		4301 N WALNUT ST			03/2023	
neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview, the facility failed to report a suspected drug diversion to the appropriate regulatory agencies for 4 of 6 residents reviewed for narcotic medication administration. (Residents H, J, K, and M)  Findings include:  1. Resident H's record was reviewed on 7/2/25 at 10:45 a.m. Diagnoses included migraine,	F 609	neglect, exploitation, must:  §483.12(c)(1) Ensure involving abuse, negl mistreatment, including source and misapprovare reported immediathours after the allegathat cause the allegathat cause the allegathat cause the allegathat cause and do not rest the administrator of the administrator of the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures.  §483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by:  Based on record revicalled to report a suspappropriate regulator residents reviewed for administration. (Resident H's recordings include:  1. Resident H's recordinates.	e that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ault in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides term care facilities) in the law through established  the results of all administrator or his or her tative and to other officials in the law, including to the State of 5 working days of the leged violation is verified the action must be taken.  To is not met as evidenced liew and interview, the facility preceded drug diversion to the yagencies for 4 of 6 or narcotic medication dents H, J, K, and M)	F	509				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303		7170312023	
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F 609	pain), and chronic p Physician orders inc oxycodone-acetamir medication) 7.5-325 tablet by mouth ever awake.  Resident H's electro record (eMAR) indic oxycodone on 6/2/25 was charted at 8:22 lpn" by LPN 15. A do for 6/2/25 at 10:00 p 9:39 a.m. as not give QMA 20. A dose sch a.m. was charted as a.m. by QMA 2 due in Resident H's narcoti the Corporate Nurse 10:36 a.m., indicated of oxycodone-acetar p.m. with forty-two ta of 12:00 a.m. and 2: narcotic sheet, but h given, or amount rer resident's narcotic ca with the count sheet remained.  During an interview of Consultant on 7/3/25 that during an interview Consultant on 7/3/25 that during an interview resident indicated LF	pain), fibromyalgia (nerverain syndrome.  Juded	F 6	09			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
		155242	B. WING _			C 07/03/2025
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F 609	Continued From pag	e 3	F 6	09		
	_	with Resident H, on 7/3/25 at unable to recall being given 6/2/25 and 6/3/25.				
	10:42 a.m. Diagnose (spinal cord defect),	rd was reviewed on 7/2/25 at es included spina bifida bilateral above knee ronic pain syndrome.				
	_	luded ophen 5-325 mg give 1 y 4 hours while awake.				
	at 12:00 a.m. was ac	nophen scheduled for 6/3/25 dministered by QMA 2 at 3:21 care", and he refused his				
	Corporate Nurse Co a.m., indicated dose on 6/2/25 at 8:00 p.n the comment "not giv 6/3/25 at 4:00 a.m. v	tic sheet, provided by the nsultant on 7/2/25 at 10:36 s were signed out by LPN 15 n., 6/3/25 at 12:00 a.m. with ven" signed by LPN 16, and with the comment "not given" and 6/3/25 at 2:00 a.m. by				
	A medication card fo provided prior to exit	r comparison was not				
	11:58 a.m. Diagnose	rd was reviewed on 7/2/25 at as included COPD, peripheral d chronic pain syndrome.				
	_	luded oxycodone 5 mg give 5 eight hours at 6:00 a.m., 2:00				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	JNCIE		STREET ADDRESS, CITY, STATE, ZIP C 4301 N WALNUT ST MUNCIE, IN 47303	ODE	1 011	00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 609	Continued From page The resident's eMAR		F 6	609				
	were given on 6/3/25	d on 6/2/25 at 10:00 p.m. at 4:00 a.m. and a dose 6:00 a.m. was given by LPN						
	the Corporate Nurse 10:36 a.m. indicated	ic count sheet provided by Consultant on 7/2/25 at a dose of oxycodone was s on 6/3/25 at 1:00 a.m. and						
	a.m. she indicated a description resident L was due at medication out of the gave the medication. Which medications she medications QMA 19 LPN 16 indicated it we someone to remove a	with LPN 16 on 7/3/25 at 9:43 dose of oxycodone for 12:00 a.m. She took the card and indicated QMA 19 She was unable to recall the administered and which administered on 6/3/25. as not appropriate for a medication from the card administer the medication.						
	10:47 a.m. Diagnoses use, restless legs syr	d was reviewed on 7/2/25 at sincluded COPD, opioid adrome, other chronic pain, erve pain) of the lumbar						
	tablet every 4 hours a	ophen 10-325 mg give 1 as needed for pain.						
		indicated she was given acetaminophen on 6/2/25 at at 10:22 a.m.						
	The resident's narcot	ic count sheet provided by						

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F 609	10:08 a.m., indicated oxycodone-acetamir LPN 15 on 6/2/25 at a.m., and 6/3/25 at 6. A medication card for provided prior to exit During an interview of the Corporate Nurses she was informed of medications, she revision for the 200 and 400 books. The narcotic thought the discrepation because the medical as signed out early. Compare the narcotic Administration Reco	Consultant on 7/3/25 at d doses of nophen were signed out by 10:00 p.m., 6/3/25 at 2:00 a.m.	F 6	09				
	Consultant on 7/3/25 no medication recon Resident M for the d 10:00 p.m., 6/3/25 at 6:00 a.m.  During an interview of QMA 2 indicated dura nurse went home of approximately between the counted the medicate with LPN 16. The national she believed somissing. QMA 2 indicated the medicate of the counted the cou	with the Corporate Nurse 5 at 10:53 a.m., she indicated ciliation was performed for oses signed out on 6/2/25 at 2:00 a.m., and 6/3/25 at on 7/3/2025 at 7:41 a.m., ing the third shift on 6/2/2025						

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	ROVIDER OR SUPPLIER	JNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE  4301 N WALNUT ST  MUNCIE, IN 47303			•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE		(X5) COMPLETION DATE
F 609	During an interview of LPN 16 indicated she that none of the medibeen passed and resuppon finding the nursured and she appeand unable to stand usent home and gave LPN 16. LPN 16 didue to it being a busy During an interview of Manager 18 indicated she received a phone that LPN 15 had been count was "off". The lot of the facility and inditing the concern when she investigated the meditation of the concern was and reported to the facility and residents, and reported to the facility and inditing the concern when she investigated the meditation of the concern was "off". The lot of the facility and inditing the concern when she investigated the meditation of the concern was provided the concern was provided to the concern was provided the concern was provided to the concern was provided to the concern was provided that the concern was provided the concern was provi	d QMA 2 reported the unit manager.  In 7/2/2025 at 9:48 a.m., a was informed by CNA 17 cation on the 200 Hall had idents were complaining. See for that hall (LPN 15), LPN eathroom. Her speech was ared disheveled, swaying up straight. LPN 15 was the medication cart keys to not count the narcotic boxes or night.  In 7/2/2025 at 9:53 a.m., Unit of on 6/3/2025 at 5:15 a.m. are call from LPN 16 stating in sent home and the narcotic Unit Manager was en route cated she would investigate the arrived. The Unit Manager ideation carts for the 200 and the counts to be "off". The swed alert and oriented and the concern to the size a.m.	F	609			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(	
		155242	B. WING _			07/	03/2025
	ROVIDER OR SUPPLIER RE HEALTHCARE OF MU	INCIE		43	rreet Address, City, State, ZIP Code 801 N WALNUT ST UNCIE, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Facility Administrator, and other appropriate accordance with Fede***Reporting Guide neglect, exploitation, misappropriation of reported to the State hours"  Cross reference F755  This citation relates to 3.1-28(c)	reported immediately to the the State Survey Agency, State and local agencies in eral and Sate law.  lines:*** Any allegation of mistreatment or esident property must be Regulatory Agency within 24		609			
F 610 SS=D	10 Investigate/Prevent/Correct Alleged Violation		F	310			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		155242	B. WING _			07/0	) 3/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 4301 N WALNUT ST MUNCIE, IN 47303	DE	1 0770	33/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA	I	(X5) COMPLETION DATE
F 610	Continued From page Based on interview failed to conduct a the suspected drug divereviewed for medicate (Residents H, K, L, and Findings include:  1. Resident H's reconstruction 10:45 a.m. Diagnose osteoarthritis (bone pain), and chronic publication orders incoxycodone-acetamin medication) 7.5-325 tablet by mouth ever awake.  Resident H's electron record (eMAR) indicoxycodone on 6/2/25 was charted at 8:22 lpn" by LPN 15. A dofor 6/2/25 at 10:00 publication 9:39 a.m. as not give QMA 20. A dose scham. was charted at 8:20 a.m. was charted as	and record review, the facility prough investigation of an resion for 4 of 6 residents tion admnistration.  Ind M)  Ind was reviewed on 7/2/25 at es included migraine, pain), fibromyalgia (nerve ain syndrome.  Inded hophen (narcotic pain milligram (mg) give one y four hours only while  Indic medication administration ated she received a dose of 5 scheduled at 6:00 p.m. but p.m. with the comment "per pose of oxycodone scheduled must be condition, signed by eduled for 6/3/25 at 2:00 refused on 6/3/25 at 4:10					
	Resident H's narcoti the Corporate Nurse 10:36 a.m., indicated of oxycodone-acetar p.m. with forty-two to of 12:00 a.m. and 2: narcotic sheet, but h given, or amount ren	to the resident sleeping.  c sign out sheet, provided by Consultant on 7/2/25 at d LPN 15 signed out a dose minophen on 6/2/25 at 10:00 ablets remaining. The times 00 a.m. were printed on the ad no signature, amount maining. A photograph of the ard provided concurrently					

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	ROVIDER OR SUPPLIER	UNCIE		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303	· · · · · · · · · · · · · · · · · · ·	01703/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	Continued From pag	e 9	F 6	10			
		indicated thirty-eight tablets e oxycodone should have					
	Consultant on 7/3/25 that during an intervi resident indicated LF	with the Corporate Nursing at 10:02 a.m., she indicated ew with Resident H, the N 15 gave her pain she received two oxycodone					
	_	with Resident H, on 7/3/25 at unable to recall being given 6/2/25 and 6/3/25.					
	_	uded ophen 5-325 mg give 1 y 4 hours while awake.					
	at 12:00 a.m. was ac	ophen scheduled for 6/3/25 Iministered by QMA 2 at 3:21 care", and he refused his					
	Corporate Nurse Con a.m., indicated doses on 6/2/25 at 8:00 p.n the comment "not give 6/3/25 at 4:00 a.m. where the control of the comment of the control of	tic sheet, provided by the insultant on 7/2/25 at 10:36 is were signed out by LPN 15 in., 6/3/25 at 12:00 a.m. with even" signed by LPN 16, and with the comment "not given" and 6/3/25 at 2:00 a.m. by					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
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F 610	F 610 Continued From page 10		F 6	510		
	A medication card fo provided prior to exit	r comparison was not				
	11:58 a.m. Diagnose	rd was reviewed on 7/2/25 at es included COPD, peripheral d chronic pain syndrome.				
	_	luded oxycodone 5 mg give 5 eight hours at 6:00 a.m., 2:00				
	were given on 6/3/25	R indicated doses of d on 6/2/25 at 10:00 p.m. 5 at 4:00 a.m. and a dose 6:00 a.m. was given by LPN				
	the Corporate Nurse 10:36 a.m. indicated	tic count sheet provided by Consultant on 7/2/25 at a dose of oxycodone was 6 on 6/3/25 at 1:00 a.m. and				
	a.m. she indicated a resident L was due a medication out of the gave the medications which medications QMA 19 LPN 16 indicated it was meaned to remove	with LPN 16 on 7/3/25 at 9:43 dose of oxycodone for at 12:00 a.m. She took the e card and indicated QMA 19. She was unable to recall the administered and which administered on 6/3/25. Was not appropriate for a medication from the card administer the medication.				
	10:47 a.m. Diagnose use, restless legs sy	rd was reviewed on 7/2/25 at es included COPD, opioid ndrome, other chronic pain, erve pain) of the lumbar				

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F 610	Continued From pa	ge 11	F 61	О			
		ncluded, inophen 10-325 mg give 1 s as needed for pain.					
		R indicated she was given e-acetaminophen on 6/2/25 at 5 at 10:22 a.m.					
	the Corporate Nurs 10:08 a.m., indicate oxycodone-acetam	inophen were signed out by it 10:00 p.m., 6/3/25 at 2:00					
	A medication card f provided prior to ex	or comparison was not iit.					
	the Corporate Nurs she was informed of medications, she re- for the 200 and 400 books. The narcotic thought the discrep because the medical as signed out early compare the narcot Administration Reco	e Consultant indicated when of the concern of missing eviewed the medication carts of Halls and the narcotic count of counts were off, but they ancies could be explained ations had been documented. The Corporate RN did not tic sheets with the Medication ord during the investigation, the count of the appropriate streets.					
	Consultant on 7/3/2 no medication reco Resident M for the	with the Corporate Nurse 25 at 10:53 a.m., she indicated nciliation was performed for doses signed out on 6/2/25 at at 2:00 a.m., and 6/3/25 at					

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			7 20.23	<u> </u>		С
		155242	B. WING _		07	//03/2025
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F 610	Continued From page	e 12	F 6	10		
	Cross reference F609	and F755.				
		o complaints IN00461866.				
F 755 SS=D	3.1-28(d) Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(	cedures/Pharmacist/Records (1)-(3)	F 7	55		
	drugs and biologicals them under an agree §483.70(f). The facili personnel to administ	ide routine and emergency to its residents, or obtain ment described in ty may permit unlicensed				
	pharmaceutical service that assure the accura- dispensing, and admi	es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.				
	- , ,	onsultation. The facility n the services of a licensed				
	§483.45(b)(1) Provide aspects of the provisi the facility.	es consultation on all on of pharmacy services in				
	. , , ,	shes a system of records of n of all controlled drugs in able an accurate				
	§483.45(b)(3) Determ	ines that drug records are in				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		155242	B. WING _			C 07/03/2025	
	NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE  4301 N WALNUT ST  MUNCIE, IN 47303		0110312023	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 755	order and that an a is maintained and properties. This REQUIREMENT by: Based on interview failed to ensure coradministration was medication amount facility policy for 4 cmedications (Resident H's reconsteoarthritis (bone pain), and chronic Physician orders in oxycodone-acetam medication) 7.5-328 tablet by mouth ever awake.  Resident H's electrorecord (eMAR) indicoxycodone on 6/2/2 was charted at 8:22 lpn" by LPN 15. A coro 6/2/25 at 10:00 9:39 a.m. as not ging QMA 20. A dose so a.m. was charted a a.m. by QMA 2 due Resident H's narcothe Corporate Nurs 10:36 a.m., indicate the corporate Nurs 10:36 a.m	cocount of all controlled drugs periodically reconciled.  NT is not met as evidenced and record review, the facility introlled medication accurately documented and is reconciled according to of 6 residents reviewed for ents H, K, L, and M)  ord was reviewed on 7/2/25 at sees included migraine, is pain), fibromyalgia (nerve pain syndrome.	F 7	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		155242	B. WING			C 07/03/2025	
	ROVIDER OR SUPPLIER	IUNCIE		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303	<u> </u>	0770072023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 755	Continued From pag		F 75	55			
	of 12:00 a.m. and 2: narcotic sheet, but h given, or amount rer resident's narcotic c with the count sheet	ablets remaining. The times 00 a.m. were printed on the lad no signature, amount maining. A photograph of the lard provided concurrently indicated thirty-eight tablets e oxycodone should have					
	Consultant on 7/3/25 that during an interv resident indicated LF	with the Corporate Nursing 5 at 10:02 a.m., she indicated iew with Resident H, the PN 15 gave her pain d she received two oxycodone					
	_	with Resident H, on 7/3/25 at unable to recall being given n 6/2/25 and 6/3/25.					
	10:42 a.m. Diagnose (spinal cord defect),	rd was reviewed on 7/2/25 at es included spina bifida bilateral above knee rronic pain syndrome.					
	_	eluded nophen 5-325 mg give 1 ry 4 hours while awake.					
	at 12:00 a.m. was a	nophen scheduled for 6/3/25 dministered by QMA 2 at 3:21 care", and he refused his					
	Corporate Nurse Co a.m., indicated dose	otic sheet, provided by the ensultant on 7/2/25 at 10:36 as were signed out by LPN 15 m., 6/3/25 at 12:00 a.m. with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENITIEICATION NITIMBED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155242	B. WING			C 07/03/2025		
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MUNCIE				4301	EET ADDRESS, CITY, STATE, ZIP CODE  1 N WALNUT ST  NCIE, IN 47303	<u> </u>	03/2029	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		RECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION NG INFORMATION) TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755	Continued From page	÷ 15	F 7	755				
	6/3/25 at 4:00 a.m. w	en" signed by LPN 16, and th the comment "not given" d 6/3/25 at 2:00 a.m. by						
	A medication card for provided prior to exit.	comparison was not						
	11:58 a.m. Diagnoses	I was reviewed on 7/2/25 at sincluded COPD, peripheral I chronic pain syndrome.						
		ided oxycodone 5 mg give 5 ght hours at 6:00 a.m., 2:00						
	were given on 6/3/25	indicated doses of I on 6/2/25 at 10:00 p.m. at 4:00 a.m. and a dose :00 a.m. was given by LPN						
	the Corporate Nurse 10:36 a.m. indicated a	c count sheet provided by Consultant on 7/2/25 at a dose of oxycodone was on 6/3/25 at 1:00 a.m. and						
	a.m. she indicated a cresident L was due at medication out of the gave the medication. which medications sh medications QMA 19 LPN 16 indicated it w someone to remove a	oith LPN 16 on 7/3/25 at 9:43 close of oxycodone for 12:00 a.m. She took the card and indicated QMA 19 She was unable to recall e administered and which administered on 6/3/25. as not appropriate for a medication from the card dminister the medication.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	COMPLETED		
		155242	B. WING		C 07/03/2025		
	ROVIDER OR SUPPLIER	MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303		07/03/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 755	4. Resident M's reconsuse, restless legs sand radiculopathy ((lower back) region  Physician orders in oxycodone-acetam tablet every 4 hours  The resident's eMA doses of oxycodone 4:51 p.m. and 6/3/2  The resident's narce the corporate nurse a.m., indicated dose oxycodone-acetam LPN 15 on 6/2/25 a.m., and 6/3/25 at  A medication card for provided prior to extend the foliation of the dose on the corporate nurse a.m., indicated the foliation of the dose on the corporate of the dose on the corporate of the dose on the corporate of the dose of t	ord was reviewed on 7/2/25 at ses included COPD, opioid yndrome, other chronic pain, nerve pain) of the lumbar.  Included, inophen 10-325 mg give 1 is as needed for pain.  IR indicated she was given e-acetaminophen on 6/2/25 at 15 at 10:22 a.m.  otic count sheet provided by e consultant on 7/3/25 at 10:08 inophen were signed out by at 10:00 p.m., 6/3/25 at 2:00 6:00 a.m.	F 75	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155242	B. WING _			C 7/03/2025	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP COL 4301 N WALNUT ST MUNCIE, IN 47303		7703/2023		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	the orientation check to all staff authorized to all staff authorized. A current facility poli Nurse Consultant or titled, "Controlled Me following: " 2. At each keys are rendered, a controlled medication members who are emedication technicia state regulations and controlled medication is completed as followed medication technicia along with the licens technician assuming controlled medication each resident's medithe narcotic drawer. The medication technician assuming count of the remaining medication account amedication count discard count discrepant by the licensed nurse.	ted the document was part of a off process and was given at to give medications.  The provided by the Corporate of 1/2/25 at 12:08 p.m. and edication", indicated the each shift change or when a physical inventory of all of its conducted by two staff of the license nurses, ans, or appropriate staff per a dis documented on the ons accountability record. This lows: a. The licensed nurse or on surrendering the keys, ed nurse or medication of the keys will review the on accountability book for ication(s) for each resident in the licensed nurse or on surrendering the keys ed nurse or medication of the keys will ensure the ong medications (s) match the ability bookb. Any screpancies or medication on the technological to the reconciled	F 7				
	A current facility poli Nurse Consultant or titled, "Drug Diversio 2. Any medications reconciled by the lice medication tech or for	ediately.  cy provided by the Corporate  a 7/2/25 at 12:08 p.m. and  on", included the following: "  s discrepancies that can't be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF D	20/4050 00 01 1001 150	135242	B. WING _	070557 4000500	OITY OTATE ZID OODE	07/	03/2025		
NAME OF P	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE				
SIGNATUI	SIGNATURE HEALTHCARE OF MUNCIE			4301 N WALNUT S					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 755	Continued From page	e 18	F	<b>'</b> 55					
	suspected incident of thoroughly investigate cannot be reconciled appropriate government	g (DON) immediately. 3. All drug diversions will be ed. 4. Any discrepancies that will be reported to all ent licensing, regulatory, and ncies."							
	law enforcement agencies."  A current facility policy provided by the Corporate Nurse Consultant on 7/3/25 at 10:51 a.m. and titled, "Medication Administration General Guidelines", indicated the following: "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices,4. Medications are to be administered at the time they are prepared. 5. The person who prepares the dose for administration is the person who administers the dose14. Medications are administered within 60 minutes of scheduled timeUnless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.  2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. 4.								

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED		
		155242	B. WING _			C <b>07/03/2025</b>	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE  4301 N WALNUT ST  MUNCIE, IN 47303			07/03/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 755	administering the me provided under the da specific medication d 5. When PRN medication d following documentat time of administration (if other applicable, the injection symptoms for which the Results achieved from time results were not person recording administration (if other applicable, the injection symptoms for which the results achieved from time results were not person recording administration administration (if other applicable) and in the results were not person recording administration and in the results were not person recording effects.	dication, in the space ate, and on the line for that ose administration and time. ations are administered, the tion is provided: a. Date and n, dose, route of er than oral), and, if on site. b. Complaints or the medication was given. c. m giving the dose and the ed. d. Signature or initials of ninistration or initials of	F 7	55			