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	11/13/2024

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 IN00446632 and IN00446869. Complaint IN00446632 - Federal deficiencies related to the allegations are cited at F600. Complaint IN00446869 - Federal deficiencies related to the allegations are cited at F686. Survey dates: November 12 and 13, 2024 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 127 Total: 127 Census Payor Type: Medicare: 6 Medicaid: 100 Other: 21 Total: 127 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 25, 2024.	F 0000	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. Signature HealthCARE of Muncie (SCHM) respectfully requests that this CMS-2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review on, or after December 13th, 2024	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on record review and interview, the facility failed to prevent verbal abuse from a staff member and failed to implement the facility abuse policy to protect the resident from the possibility of further	F 0600	* what corrective action(s) will be accomplished for those residents found to have been affected by the deficient	12/09/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daphne New	Administrator	12/07/2024

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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	abuse for 1 of 3 residents reviewed for abuse. (Resident F) Findings include: An 11/5/24, facility self-reported incident indicated the following: "Brief Description of Incident": A resident reported that a staff member was impatient, making comments regarding her incontinence and pushed her back towards the bathroom when the resident attempted to leave bathroom. The immediate actions taken were the completion of a skin assessment with no signs of injury and the suspension of the staff member pending an investigation. The Director of Nursing, Administrator, and Physician were notified. Preventative measures taken included the social services department was to do a psychosocial follow-up and the staff member was to remain suspended pending investigation. Resident F's clinical record was reviewed on 11/12/24 at 3:11 p.m. Diagnoses included unspecified convulsions, adult failure to thrive, and need for assistance with personal care. An 11/7/24, Discharge Minimum Data Set (MDS) Assessment indicated the resident was dependent for all Activities of Daily Living (ADL's). The Brief Interview for Mental Status (BIMS) was not performed. An "ADL's Functional Status" care plan, initiated 8/26/24, indicated the resident had a decline in ability to perform ADL's and needed assistance. Approaches indicated to assist and encourage the resident to turn and reposition periodically, for staff to provide assistance as needed to ensure daily needs are met, and assist with transfers.		practice; Resident F was monitored for psychosocial wellbeing with no adverse effects noted, CNA was removed from the room at the time of the occurrence and suspended. No adverse effects noted. *how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Abuse investigation was completed that includes resident interviews and skin assessments were conducted on non interviewable residents with no concerns noted. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All staff in-serviced on recognizing and reporting abuse and protocol. 5 employees per week will be audited to ensure they can identify, define & report abuse as well as protect residents. Audits to occur weekly for 4 weeks, then every other week for 2 months, then monthly for 3 months. Audits will be brought to monthly QAPI *how the corrective action(s) will be monitored to ensure the	

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	A review of the facility investigation file, provided by the Administrator on 11/13/24 at 1:05 p.m., included, but was not limited to, the following: An 11/6/24, written statement from CNA 4 indicated CNA 5 was talking loudly in the hall about Resident F being "nothing but a problem all night". An 11/6/24, written statement from CNA 6 indicated CNA 5 yelled down the hallway to ask for help with Resident F. CNA 6 noticed Resident F had feces on her bed sheets and hands and was "whining". CNA 6 told Resident F to walk to the restroom and wash her hands so the staff could change the bed sheets. Resident F refused and CNA 5 said "get your f---ing a-- up". CNA 6 asked CNA 5 not to talk to the resident like that. CNA 6 encouraged the resident to get up and the resident was seated on the edge of the bed. CNA 5 said "I got it from here". CNA 6 exited the room and continued with her assigned tasks. An 11/6/24, written statement from RN 7 indicated she did not hear the abusive language to Resident F, but had observed CNA 5 having an "attitude" with RN 7 and other staff all night. An undated, written statement from the Administrator indicated multiple attempts to contact CNA 5. During a phone call conversation on 11/6/24, CNA 5 got upset about the allegation of abuse and indicated she was not sure she wanted to work at "a place like that". CNA 5 indicated Resident F was a mess all night but CNA 5 was not abusive to the resident. CNA 5 provided no written statement related to the abuse allegations. A review of CNA 5's employee file, on 11/13/24 at		deficient practice will not recur, i.e., what quality assurance program will be put into place: 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 of audits.	

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	1:41 p.m., indicated her hire date was 10/22/24. A "Day 1: New Hire Orientation" curriculum, printed 11/13/24, indicated CNA 5 completed resident rights and abuse training by 11/5/24. During a phone interview, on 11/13/24 at 1:23 p.m., CNA 6 indicated CNA 5 asked her for assistance with Resident F. The resident had feces on the bed sheets and her hands. Resident F was able to walk and she asked the resident to walk to the restroom to wash her hands. Resident F continued to lay in bed and that was when CNA 5 said "get your f---ing a-- up" to the resident. CNA 6 told CNA 5 not to talk like that to a resident. CNA 6 left the room and directly reported the incident to RN 7. CNA 6 felt it was okay to leave Resident F alone with CNA 5. During an interview, on 11/13/24 at 1:41 p.m., the Administrator indicated the investigation concluded with no substantiation of abuse. She indicated there was no risk to Resident F's safety when she was left with CNA 5. The Administrator felt her staff acted appropriately and followed the facility policy. A facility policy, revised on 9/15/23, titled "Abuse, Neglect, and Misappropriation of Property," provided by the Administrator on 11/12/24 at 11:22 a.m., indicated the following: "...It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or state law which involve abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency			

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	and other appropriate State and local agencies in accordance with Federal and State law...Verbal Abuse is 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...If a Stakeholder observes any form of abuse, the Stakeholder will intervene immediately, remove and or separate residents involved, and move them to an environment where the residents' safety can be assured..." This citation relates to Complaint IN00446632. 3.1-27(a) 3.1-27(b)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review and interview, the facility failed to accurately and consistently assess a new pressure injury and failed to promptly initiate wound treatment to promote healing of pressure injury for 1 of 3 residents reviewed for pressure injuries. (Resident B). Findings include: Resident B's closed clinical record was reviewed on 11/12/24 at 11:07 a.m. Diagnoses included ventricular tachycardia, subsequent encounter for closed fracture of the neck of the left femur, muscle weakness, and unspecified dementia. A 9/3/24, Admission Minimum Data Set (MDS) Assessment indicated Resident B was cognitively intact, had no wounds or pressure ulcers, and	F 0686	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Resident B was reviewed with orders in place and no worsening of the wound related to the alleged deficient practice * how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with wounds have the potential to be affected. All resident with current wounds have been reviewed to ensure orders are in place. No concerns noted	12/13/2024

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	required partial assistance from staff for bed mobility and transferring. A skin integrity care plan, initiated 9/3/24, indicated the resident was at risk for pressure ulcers related to decreased mobility. Approaches included to report changes in skin status and to complete treatments per physician order. A "Skin Integrity Event", dated 9/9/24, indicated a skin tear to the sacrum, measuring 2.5 centimeters (cm) length x 2.0 cm width x 0.1 cm depth, the size of a quarter. There were small amounts of blood loss and the wound had smooth edges. The nurse practitioner was notified and staff to monitor the skin tear for signs and symptoms of infection. A "Wound Management Detail Report", dated 9/9/24, indicated the resident had an area on the sacrum measuring 4.0 cm length x 4.0 cm width x 0.3 cm depth, roughly the size of a golf ball. There were light amounts of serosanguineous (watery, pale red to pink) drainage. A "Nursing Progress Note", dated 9/9/24, indicated an open area to the sacrum which appeared to be a skin tear. The nurse practitioner was notified and a comfort dressing was to be put into place. The clinical record lacked indication of treatment orders for the skin impairment, including a "comfort dressing". A "Wound Management Detail Report", dated 9/11/24, indicated an area to the sacrum measuring 3.8 cm length x 3.9 cm width x 0.3 cm depth, roughly the size of a golf ball. There were light amounts of serosanguineous drainage.		*what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All licensed nurses to be educated by the DON on obtaining and placing treatment orders for wounds. The DON, or designee will complete an audit of 5 residents with wounds, as available, to ensure that treatment orders are in place. The audit will be completed weekly x4 weeks, then every other week x2 months, then monthly x3 months *how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 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 of audits	

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	A "Nursing Progress Note", dated 9/11/24, indicated the skin tear to the coccyx remained without signs of infection and the protective dressing was changed due to soilage. A "Wound Management Detail Report", dated 9/18/24, indicated an unstageable (full-thickness tissue loss that's covered) pressure ulcer to the sacrum measuring 3.0 cm length x 4.0 cm width, roughly the diameter of a D battery. There was slough (dead tissue, white in color that prevents healing) covering half the wound surface. The wound healing status was declining. A physician's order, dated 9/20/24, indicated to clean the sacrum area with sterile water, pat dry, and apply Santyl (a debriding wound treatment) to the wound bed and cover with a foam dressing daily. The clinical record lacked a physician's order for treatment of Resident B's unstageable pressure ulcer prior to 9/20/24. The clinical record referred to the same wound/pressure area using different wound types. The facility failed to develop and implement a care plan with individualized interventions to support the healing of the pressure injury to Resident B's sacrum. The resident discharged from the facility on October 1, 2024, with the wound present. During an interview, on 11/12/24 at 1:45 p.m., RN 3 indicated when a new skin area was found by staff, they completed the skin event and contacted the physician to obtain any orders. Then they would notify the Unit Manager or Director of Nursing and document in the clinical			

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	record. During an interview, on 11/12/24 at 2:25 p.m., the DON indicated Resident B's wound was first documented on 9/9/24 as a skin tear. On 9/11/24, he reclassified it to a pressure ulcer. The floor staff try to get as much information as possible into the skin events, but sometimes wounds are not categorized correctly. He indicated there was a protective dressing on the wound according to the progress notes. He was not able to locate any treatment orders until the one dated 9/20/24. A facility policy, revised 9/15/23, titled, "Skin Integrity", provided by the DON on 11/13/24 at 11:04 a.m., indicated the following: "...A resident with impaired skin integrity receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infections and prevent avoidable skin integrity issues from developing..." This citation relates to Complaint IN00446869. 3.1-40(a)(2)			