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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435272, IN00435893, IN00436790, IN00436945 and IN00438076. Complaint IN00435272 - No deficiencies related to the allegations are cited. Complaint IN00435893 - No deficiencies related to the allegations are cited. Complaint IN00436790 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00436945 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00438076 - Federal/state deficiencies related to the allegations are cited at F600 and F609. Survey dates: July 2, 3, and 5, 2024 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 120 Total: 120 Census Payor Type: Medicare: 5 Medicaid: 99 Other: 16 Total: 120 These deficiencies reflect State Findings cited in	F 0000	*This plan of correction is the center's credible allegation of compliance.* *Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Hobbs	RN, DON	07/29/2024

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.

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accordance with 410 IAC 16.2-3.1. Quality review completed July 15, 2024.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record review, the facility failed to ensure a resident was free from verbal abuse from a staff member for 1 of 3 residents reviewed for abuse. (Resident F) Findings include: During an interview with Resident L, on 7/3/24 at 11:03 a.m., she indicated she witnessed CNA 6 tell Resident F that the resident needed to get out of the facility. She didn't need to live there, and needed to move in with her ex-husband and "mooch" off him. The CNA also told Resident F that her grandkids didn't love her. During an interview with Resident K, on 7/3/24 at 11:58 a.m., she indicated she had witnessed CNA 6 arguing with Resident F because she	F 0600	Deficiency ID: F600 Free from Abuse and Neglect Completion Date: 7/27/24 Plan of Correction Text 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. a Resident F has received psychosocial follow up relating to incident with CNA 6 as well as care plan updated. b CNA 6 employment has been terminated. 2 How will other residents having the potential to be affected	07/27/2024

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	intentionally did not pass ice to Resident F. Resident F reported it, and CNA 6 told Resident F that she was a bully and she needed to move back in with her husband and that her children only wanted her for her money. During an interview with Resident F, on 7/3/24 at 12:29 p.m., she indicated CNA 6 would not give her ice water and told her that she had to get her own, although she was not supposed to be in the area where the ice was located. This was also the same with linens. She had been living at the facility for six months and she had to change her own linens and retrieve the linens from the linen closet. She reported that she felt CNA 6 intentionally did not pass ice water to her. After she reported it, CNA 6 followed her down the hall and told Resident F that she got her into trouble, and she needed to find another place to live. She needed to go home to live with her husband and the only reason her children and grandchildren came to visit her in the facility was for her money. She responded with negative comments related to CNA 6's personal life. Resident F rolled up to CNA 6 in her wheelchair and Resident F's knees touched CNA 6. CNA 6 began to yell that she wanted Resident F to be arrested and sent to jail. RN 12 was present and separated them. During an interview with the Administrator, on 7/3/24 at 4:18 p.m., he indicated Resident F came to his office with concerns regarding CNA 6 not giving her ice water and felt CNA 6 had singled her out. CNA 6 had seen Resident F come from his office and approached Resident F and said to her "You told on me." Later, Resident F, CNA 6, and RN 12 were in his office, at some point CNA 6 claimed Resident F slammed into her with the wheelchair and Resident F indicated CNA 6 was on her phone rather than working. CNA 6 felt		by the same deficient practice be identified and what corrective action(s) will be taken: a Other residents residing at Signature of Muncie have the potential to be affected by the alleged deficient practice. b Residents were interviewed by DON, CEO, or designee to identify concerns of abuse. c Staff members were interviewed by DON, CEO or designee to identify concerns of abuse. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a All staff will be re-educated on the existing facility's policy of" Abuse, Neglect and Misappropriation of Property." 4 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: a Random audits on abuse will be given consisting of three questions to three residents per day. Audits will be conducted by CEO, DON, or designee. Audits will be conducted Monday – Friday for four weeks, then three times weekly for four weeks, then twice weekly for one month, then one time weekly for three months to ensure residents are free from	

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident F bullied staff. The Administrator decided he needed to meet with them individually rather than them talking over each other. He asked CNA 6 to leave, and she was suspended pending the investigation. He was waiting on the Human Resource (HR) to review the situation. His biggest concern was that CNA 6 had an inappropriate verbal altercation with a resident. They are supposed to be equipped for that type of behavior; staff could not and should not engage. An altercation could turn into verbal abuse or worse. CNA 6 and Resident F were virtually separated immediately. RN 12 told CNA 6 and Resident F to go to the Administrator's office. During an interview with CNA 6, on 7/3/24 at 4:35 p.m., she indicated the Scheduler had told her that Resident F wanted CNA 6 moved off her hall and wanted to get her fired. CNA 6 asked Resident F about it. CNA 6 told Resident F that her grandkids don't come to see her because she didn't have any money to give to them. She knew she shouldn't have said that to her. Resident F verbally assaulted her by making a comment about her personal life. Resident F was in her wheelchair and ran over her toes and ran into her legs, which left bruising on her legs. When they were all in the Administrator's office, she told him she was going to call the police on Resident F and have her arrested for battery. Resident F's clinical record was reviewed on 7/3/24 at 12:19 p.m. Diagnoses include peripheral vascular disease, muscle weakness (generalized), need for assistance with personal care, difficulty in walking, not elsewhere classified, major depressive disorder, single episode, anxiety disorder, and unspecified lack of coordination. Her orders included alprazolam (treat anxiety) 0.5		abuse. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 6 months, or until the QAPI committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mg (milligram) four times daily, trazodone (treat depression) 75 mg daily, and venlafaxine (treat depression) 225 mg daily. A quarterly Minimum Data Set (MDS), dated 4/1/24, indicated she was cognitively intact. She required supervision for bed mobility, transfers and toilet use. No behaviors were exhibited. Her clinical record lacked a care plan and nurses notes related to the incident with CNA 6. A current facility policy, titled "Abuse, Neglect and Misappropriation of Property," provided by the Nurse Consultant on 7/3/24 at 4:51 p.m., indicated the following: "...Definitions ...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 hearing distance, regardless of age, ability to comprehend, or disability....." This citation relates to complaint IN00438076. 3.1-27(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, 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			

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 procedures. §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. Based on interview and record review, the facility failed to report an allegation of abuse to the State Agency in a timely manner for 1 of 3 reportable abuse allegations reviewed. Findings include: A facility reported incident indicated an allegation of verbal abuse occurred on 6/27/24 at 4:45 p.m. when Resident F alleged CNA 6 intentionally skipped providing ice water to her because CNA 6 felt Resident F could get it herself. This led to a loud verbal exchange during which "angry" language was used by each party. The confirmation email for the incident indicated it was submitted to the Indiana State Department of Health on 6/30/24 at 8:27 a.m. During an interview with the Administrator, on	F 0609	Deficiency ID: F609 Reporting of Alleged Violations Completion Date: 7/27/24 Plan of Correction Text 609 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. a There were no residents affected by the deficiency. 2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken: a The facility will ensure that all alleged violations involving	07/27/2024

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7/3/24 at 4:18 p.m., he indicated abuse was to be reported within 24 hours unless it involved physical abuse, then it was to be reported within two hours. A current facility policy, titled "Abuse, Neglect and Misappropriation of Property," provided by the Nurse Consultant on 7/3/24 at 4:51 p.m., indicated the following: "...Reporting Guidelines: Any abuse allegations must be reported to State within 2 hours from the time the allegation was received...." Cross reference F 600. This citation relates to complaint IN00438076. 3.1-28(c)		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. b The Facility will 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. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a All staff will be re-educated on the existing facility's policy of" Abuse, Neglect and Misappropriation of Property." b All staff educated on the proper procedure for reporting abuse and neglect in a timely manner per state and federal regulations. c CEO gave cell phone number to all staff and posted it at nurses stations as well as high traffic areas. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			i.e., what quality assurance program will be put into place: a Random audits on abuse will be conducted consisting of three questions to three stakeholders per day. Audits will be conducted by CEO, DON, or designee. Audits will be conducted Monday – Friday for four weeks, then three times weekly for four weeks, then twice weekly for one month, then one time weekly for three months to ensure residents are free from abuse. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 6 months, or until the QAPI committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure dependent residents received showers/bed baths per the resident care plan and resident preference for 2 of 4 residents reviewed of activities of daily living. (Residents E and M)	F 0677	Deficiency ID: F677 Completion Date: 7/27/24 Plan of Correction Text	07/27/2024

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. The clinical record for Resident E was reviewed on 7/5/2024 at 11:21 a.m. Diagnoses included cerebral infarction, hydronephrosis, chronic obstructive pulmonary disease, need for assistance with personal care, muscle weakness, dysphagia, anxiety disorder, depressive disorder, osteoarthritis, hearing loss, and chronic pain syndrome. The most recent quarterly Minimum Data Set (MDS) assessment indicated Resident E was cognitively intact and required supervision and touch assistance for showers and shower transfers. Review of the facility shower schedule indicated Resident E was scheduled for showers on Mondays, Thursdays and Saturday evenings. Review of Resident E's care plans indicated bathing preferences had not been assessed and recorded. Review of Resident E's care plans indicated a history of refusal for treatment/care as evidenced by refusal for as needed prune juice, labs and medications for bowel movements. Review of the clinical record indicated from 6/5/24 through 7/4/24, Resident E received four showers. The resident was scheduled for 12 showers during the same 29-day period. During an interview on 7/5/24 at 10:39 a.m., Resident E indicated they preferred showers. The resident indicated showers were scheduled on Mondays, Thursdays and Saturdays in the		1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. a Due to confidential resident roster residents are unknown. All resident preferences regarding shower/bed bath have been updated. 2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken: a Other residents residing at Signature of Muncie have the potential to be affected by the alleged deficient practice. b All residents shower/bed bath preferences have been updated to ensure clear communication. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a Care staff will be re-educated on facility policy of “Resident Rights and Activities of Daily Living”. b DON or designee will interview two resident’s weekly that require assistance with showers/bathing. Any issue identified will be addressed immediately. 4 How the corrective action(s)	

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	evening. Sometimes they (staff) told her they did not have time for her showers. This happened most of the time. "I usually have to do it myself." During an interview on 7/5/24 at 12:34 p.m., CNA 12 indicated Resident E reminded staff off her shower days. CNA 12 indicated they worked 6:00 a.m. to 6:00 p.m. and attempted to get at least one of the evening showers done in addition to the day shift showers.2. During an interview on 7/3/24 at 11:22 a.m., Resident M indicated she had not been getting a complete bed bath on schedule for some time. Her hair had not been washed for at least three weeks. She received quick wash-ups, when staff change her brief. She preferred a complete bed bath when she got into bed at night due to her being transferred using a mechanical life and not wanting to transfer more than she had to. The clinical record for Resident M was reviewed on 7/5/24 at 10:14 a.m. Diagnoses included right heart failure, atrial fibrillation, morbid obesity, and need for assistance with personal care. The most recent quarterly MDS assessment, dated 4/5/24, indicated the resident was cognitively intact and was dependent on staff for bathing. Review of the facility shower schedule indicated Resident M was scheduled for a complete bed bath on Tuesday, Thursday and Saturday. A current health care plan, updated 4/16/24, regarding ADL (activities of daily living) functional status included Resident does not like to have showers, is "deathly afraid" of water in her face. An approach indicated staff to provide assistance as needed with all ADL care to ensure		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: a Audits will be conducted by DON, or designee on two resident's weekly that require assistance with showers/bathing. Audits will be conducted Monday – Friday for twelve weeks to ensure residents rights are honored. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 6 months, or until the QAPI committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily needs were met. Review of the resident's ADL bathing record indicated from 6/5/24 through 7/5/24, Resident M received two complete bed baths. The resident was scheduled for 13 complete bed baths during that 30-day period. During an interview on 7/3/24 at 11:41 a.m., QMA 13 indicated day shift got their assigned showers completed. Evening shift did not get the assigned showers completed. Staff offered bed baths, but they did not replace getting a shower. During an interview on 7/5/24 at 11:20 a.m., CNA 7 indicated Resident M was scheduled for a complete bed bath in the evening. She had given her a partial bed bath during the day shift as part of her care. The resident had shared with her before that she had not been getting her complete bed baths. The resident had not refused care. She indicated the resident told her she preferred her bath at 9:00 p.m. when she was transferred to bed for the night. During an interview on 7/5/24 at 3:40 p.m., the Corporate Nurse Consultant indicated resident's should have their preferences met regarding time of bathing and hygiene. A current facility policy, revised 9/15/23, titled, "Resident Rights," provided by the Corporate Nurse Consultant on 7/5/24 at 3:56 p.m., included the following: "...Policy Statement All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility. All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life...."			

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This citation relates to complaint IN00436945. 3.1-38(b)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and			

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	periodically reconciled. Based on interview and record review, the facility failed to ensure physician ordered medication was obtained to continue treatment for a resident for 1 of 1 residents reviewed for neglect. (Resident B) Findings include: The closed clinical record for Resident B was reviewed on 7/2/24 at 6:45 p.m. Diagnoses included anemia, nausea with vomiting, history of stroke with right side hemiplegia, and copper deficiency. The resident was admitted to the facility on 6/7/24 at approximately 7:00 p.m., from an acute care hospital stay. The hospital discharge orders included copper sulfate (supplement) 2 mg (milligram) daily for the duration of 30 days for anemia due to gastrointestinal blood loss. A physician hematology consultation report, dated 6/3/24, completed during the resident's acute hospital stay included the following: Copper deficiency. Start copper sulfate 2 mg orally daily, to continue even on discharge, for 1 month. The resident's physician admission orders, dated 6/7/24, included Copper Sulfate (cupric sulfate (bulk)) crystals, 2 ml (milliliter) daily for anemia due to gastrointestinal blood loss. The order was discontinued 6/7/24. A physician's order, dated 6/7/24, indicated Copper Sulfate (cupric sulfate (bulk)) crystals, 2 ml daily for anemia due to gastrointestinal blood loss. The order was discontinued 6/9/24. A physician's order, dated 6/9/24, indicated, Copper Sulfate (cupric sulfate (bulk)) crystals, 2	F 0755	Deficiency ID: F755 Completion Date: 7/27/24 Plan of Correction Text 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. a Resident B is no longer a resident of the facility. 2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken: a Other residents residing at Signature of Muncie have the potential to be affected by the alleged deficient practice. b All residents with medication orders will be reviewed for compliance with monitoring for the last 7 days. Report of “unavailable” drugs for the last 7 days will be reviewed, and MD and pharmacy will be made aware as necessary. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a Nursing staff will be re-educated on facility policy of “Medication Orders Non-Controlled Medication Orders”.	07/27/2024

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mg (milligrams) daily for anemia due to gastrointestinal blood loss. The order was discontinued 7/7/24. A nurse practitioner progress note, dated 6/10/24, indicated, during the resident's acute hospital stay, she had an undetectable copper level which led to the addition of Copper Sulfate 2 mg daily. A noted assessment and plan included to continue copper sulfate 2 mg once daily through July 7, 2024, for the resident's anemia. During a telephone interview on 6/5/24 at 10:43 a.m., the Pharmacy Technician indicated the order for copper sulfate was received by the pharmacy on 6/8/24 at 11:00 p.m. (52 hours after resident was admitted). This information was processed and entered for pharmacy staff on 6/9/24 at 7:00 p.m., and available to pharmacy staff on 6/10/24. She indicated the pharmacy did not have this medication in stock and an email was sent to the facilities Director of Nursing on 6/10/24 at 7:46 p.m. During an interview on 7/5/24 at 11:43 a.m., the DON indicated the copper sulfate had not been received with the rest of Resident B's medications. The nurse practitioner was notified of the delay on 6/11/24. The DON indicated the staff should have contacted the pharmacy when the medication had not arrived with the resident's other medications. A nursing progress note, dated 6/11/24 at 10:30 a.m. as a late entry note on 6/12/24 at 10:08 a.m., indicated the facility was notified by pharmacy that the copper 2 mg supplement could not be obtained. During a telephone interview on 7/5/24 at 12:29		b DON or designee will audit 5 records weekly to ensure medication availability according to MD orders. Any issue identified will be addressed immediately. 4 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: a Audits will be conducted by DON, or designee on 5 resident's records. Audits will be conducted Monday – Friday for twelve weeks to ensure resident medications are available and MD is notified of any unavailable medications. b Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 6 months, or until the QAPI committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	07/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., the Nurse Practitioner indicated she had been unaware the copper sulfate was unavailable until Monday, 6/10/24. She was aware the DON had attempted to get the copper sulfate from another vendor and finally ordered the supplement from an online source on 6/11/24. The medication needed to be administered due to the continued order from the hospital. She had not given an order to place the medication on hold. A current facility policy, dated 1/23, titled, "Medication Orders Non-Controlled Medication Orders," provided by the Corporate Nurse Consultant on 7/3/24 at 4:51 p.m., included the following: "...Procedures Elements of the Medication Order:...4. The prescriber shall be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not available...." This citation relates to complaint IN00436790. 3.1-25(a)			