AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155242	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/12/2023	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP COD 4301 N WALNUT ST MUNCIE, IN 47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F 0000 Bldg. 00	IN00416092, IN004 IN00416923. Complaint IN00416 related to the allega Complaint IN00417 related to the allega Complaint IN00417 the allegations are complaint IN00416 These deficiencies reaccordance with 416 These deficiencies reaccordance with 416 These deficiencies reaccordance with 416	1923- No deficiencies related to ited. 1923- No deficiencies related to ited. 20146 20146 201200 20146 201200	F 00	000	It is the practice of this provide ensure that federal participation requirements for nursing home participating in Medicare &/or Medicaid programs are met in accordance with federal and solaw. This provider respectfully requite that this CMS-2567 Plan of Correction be considered the Letter of Credible Allegation Compliance and requests a dereview in lieu of a post-survey review on, or after 10/10/2023 = "" span	on es tate ests on of esk	

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

Eric Ahlbrand CEO 10/01/2023

Any defiency statement 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155242	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/12/2023		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP COD 4301 N WALNUT ST MUNCIE, IN 47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0600 SS=D Bldg. 00	Exploitation The resident has to abuse, neglect, moroperty, and explosubpart. This inclusive freedom from corpinvoluntary seclusive chemical restraint resident's medical §483.12(a) The faction of physical abuse involuntary seclusive Based on interview failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 2 of 3 residents review failed to prevent stace 3 review of 4 facility indicated the reside 3 review of a facility indicated on 8/25/2 review of a fa	from Abuse, Neglect, and the right to be free from isappropriation of resident oitation as defined in this udes but is not limited to oral punishment, ion and any physical or not required to treat the symptoms. cility must- use verbal, mental, sexual, corporal punishment, or ion; and record review the facility ff to resident verbal abuse for ewed for abuse. (Residents B,	F 0600	1. Resident B has been assessed for any changes wit mental status, anguish, or distress. The allegation Resider B discussed with the surveyor already been reported to IDO with the investigation completed The care plan has been updareflect the current status of the resident. Resident # D was assessed by the Social Service Director and Director of Nursi upon report of the negative statements. There were no so for a change in mental status, resident was free of signs or symptoms of mental anguish distress. There were no visib changes to resident appearar skin. The care plan has been updated to reflect the current status of the resident. Resident.	dent r had H red. ted to e ces ng igns or le nce or		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
155242		155242	B. W	ING		09/12	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF P	PROVIDER OR SUPPLIEF	₹			WALNUT ST		
SIGNIATI	JRE HEALTHCARE				E, IN 47303		
SIGNATO	JAL HEALTHUARE	- OI WONCIE		IVIOINCI	L, IIV 47 JUJ		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					was visited by facility staff and	I	
	_	v, on 9/11/2023 at 11:58 a.m.,			assessed for any changes in		
		d CNA 13 cussed him out			mental status, anguish, or		
	-	assistance getting off the			distress. No changes were		
	_	n he needed to "get his a			noted. Resident P could not b	e	
		athroom. "She would not let it			identified.		
		g and cussing. Finally, I lost it			A one-time resident interview		
	and started yelling l	back."			process has been completed t		
					the current population, comple		
		ord for Resident D was reviewed			on 9/26/23, with no other issue	es	
		5 p.m. Diagnoses include			identified during the		
		pulmonary disease, chronic			interview/resident assessment	t	
		chronic kidney disease,			process. An Ad Hoc QAPI		
		2 diabetes mellitus, and			meeting was held on 9/27/23 v	with	
	peripheral vascular	disease.			the Medical Director and QAP		
					Team. The facility staff have I		
		current quarterly Minimum			re-educated on abuse prohibit	ion,	
	, , ,	sessment, dated 5/26/2023,			to include verbal abuse.		
		nt was moderately cognitively			It is the responsibility of the fa	cility	
	impaired.				staff to uphold the abuse		
					prohibition policy and procedu		
	-	v on 9/11/2023 at 11:58 a.m.,			and to refrain from swearing a	nd	
		ed on 9/10/2023, they witnessed			yelling while working in the		
		between Resident D and CNA			facility. The Director of Nursin	_	
		was being verbally abusive to			Assistant Director of Nursing,		
		ng and using inappropriate			Manager, Shift Supervisor, Cli	nical	
	language. The alter	reation was witnessed by other			Consultant, and/or the		
	residents.				Administrator will be responsit	ole	
					to interview staff on abuse		
	-	v on 9/11/2023 at 1:45 p.m., RN			prohibition, including if there h		
		0/2023, they witnessed			been any situation not reporte	d	
	_	ce from the ice chest in the			immediately to the Abuse		
	clean utility room. CNA 14 started yelling at the				Coordinator 3 times a week fo		
		ent was in a wheelchair and			four weeks, two times weekly		
	_	out of the clean utility room.			(4) four weeks; weekly for (4)	four	
		gry. The resident and CNA 14			weeks; then monthly for three		
		priate words. The resident			months. Any issues identified	will	
	punched RN 11 in t	he stomach. It was unknown if			be immediately corrected, 1:1		
	the punch was defle	ected. CNA 14 took the cup of			re-education completed for		
	ice and shoved it in	the resident's direction and	1		stakeholder as identified up to		ĺ

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	ETED	
		155242	B. WIN	NG		09/12/	2023
			— т	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹			WALNUT ST		
SIGNATURE HEALTHCARE OF MUNCIE					E, IN 47303		
		- O. WIGHTOIL		WICHOI	L, 77 000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		oor. CNA 14 walked away. The			and including disciplinary action		
		room. The incident was			as determined necessary by the	ne	
		st two residents and other staff			Administrator and Director of		
		ould not remember the names of			Nursing.		
		bers. RN 11 did not report the			The Administrator will review t	he	
		know I had to report this kind			audits completed on a weekly		
	of thing, no one tole	d me I had to report it."			basis. Results of the reviews	will	
	D ' (D) (44)	1 2 12 13			be forwarded to the Quality		
		education record indicated the			Assurance Performance		
		ved abuse reporting education			Improvement Committee mont	-	
	on 6/29/2023.				for 3 months, and then quarter	ТУ	
	D	0/11/2022 -4 2:28			for 3 quarters. Based on		
	_	v, on 9/11/2023 at 2:38 p.m.,			evaluation of audits and	:44	
		d during the past weekend to the clean utility room to get			observations, the QAPI Comm	iittee	
		d cussing and yelling at			determined the facility is in		
		out of that room. CNA 14 told			substantial compliance on 10/10/23. Audit documentatio	n	
		s the reason things were			will continue to be submitted to		
		nd the facility because the			the QAPI committee for review		
		hing things. Resident D stood			to ensure compliance goals.	anu	
		hair. CNA 14 asked Resident D			QAPI committee reserves the	riaht	
	-	nit him and then told him to go			to modify or extend monitoring	-	
		nd called him an inappropriate			times according to outcomes.	l	
		went to his room and CNA 14			The Administrator is responsible	le.	
	walked away.	went to mo room and ervir i			for the oversight of this plan to		
	wanted away.				ensure ongoing compliance.		
	During an interview	v on 9/12/2023 at 9:26 a.m.,			2care angoing compliance.		
	_	on 9/10/2023, he heard CNA 14					
		et out of the "f _ king ice".					
		to yell at Resident D and					
		appropriate language. CNA 12					
		ld have reported the incident					
	to the Administrator but did not.						
	A current policy, da	ated 5/27/2016 and last					
		2022, titled "Abuse, Neglect					
		on of Property" was provided					
		1/23 at 9:40 a.m. and indicated					
	the following:						
	"Policy Statement	t It is the organization's					
	i e		1		l e e e e e e e e e e e e e e e e e e e		i

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155242			JILDING	nstruction 00	(X3) DATE COMPL 09/12/	ETED	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE		STREET ADDRESS, CITY, STATE, ZIP COD 4301 N WALNUT ST MUNCIE, IN 47303					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0609 SS=D Bldg. 00	neglect, exploitation and misappropriation assure that all allege laws which involve injuries of unknown of resident property immediately to the State Survey Agenciand local agencies in State law". This Federal tag released and local agencies in State law". This Federal tag released and local agencies in State law". This Federal tag released and local agencies in State law". This Federal tag released and local agencies in State law". **State Survey Agencian development of the State Survey Agencian and local agencies in State law". This Federal tag released and local law in State law proving exploitation or missinguries of unknown in misappropriation of the compact of the state law provides administrator of the officials (including Agency and adult state law provides state law provides and misappropriation of the officials (including Agency and adult state law provides and state law provides and state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the officials (including Agency and adult state law provides and misappropriation of the	ed Violations conse to allegations of conse to allegations of conse to allegations of conse to allegations of conservation, or mistreatment, ure that all alleged g abuse, neglect, ctreatment, including n source and of resident property, are cely, but not later than 2 cegation is made, if the the allegation involve abuse s bodily injury, or not later e events that cause the nvolve abuse and do not					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155242	B. W.	B. WING			09/12/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					WALNUT ST			
SIGNATURE HEALTHCARE OF MUNCIE				1	IE, IN 47303			
					,		T	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION	
TAG	1	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	through established	ed procedures.						
	C400 40(-)(4) D							
		port the results of all						
	_	he administrator or his or						
	_	presentative and to other						
		ance with State law,						
	I -	tate Survey Agency, within the incident, and if the						
		s verified appropriate						
	corrective action r							
		s and record review, the facility	F 00	600	Resident B has been		10/10/2023	
		gations of staff to resident	1 0	009	assessed for any changes wit	h	10/10/2023	
	_	egations of abuse reviewed			mental status, anguish, or	11		
	(CNA 14 and Resid				distress. The allegation Resid	lent		
	(B discussed with the surveyor			
	Findings include:				already been reported to IDOI			
					with the investigation complete			
	The clinical record	for Resident D was reviewed			The care plan has been updat			
	on 9/11/2023 at 3:2	25 p.m. Diagnoses include			reflect the current status of the			
		pulmonary disease, chronic			resident. Resident # D was			
	respiratory failure,	chronic kidney disease,			assessed by the Social Service	es		
	hypertension, Type	2 diabetes mellitus, and			Director and Director of Nursin			
	peripheral vascular	disease.			upon report of the negative			
					statements. There were no si	gns		
		t current quarterly Minimum			of a change in mental status,			
	` ′	sessment, dated 5/2/2023,			resident was free of signs or			
	indicated the reside	ent was moderately cognitively			symptoms of mental anguish			
	impaired.				distress. There were no visible			
					changes to resident appearan			
	1	v Employee 7 indicated they			skin. The care plan has been			
		using an "excessively loud			updated to reflect the current			
		riate language with Resident			status of the resident. Reside			
		indicated they felt CNA 14 was			was visited by facility staff and	ł		
		towards Resident D. Employee			assessed for any changes in			
	_	incident. They indicated they			mental status, anguish, or			
	-	ed the incident to the			distress. No changes were			
	Administrator.				noted. Resident P could not b	е		
	D	0/11/2022 / 1 / 5			identified.			
	_	v on 9/11/2023 at 1:45 p.m., RN			A one-time resident interview	•		
	11 indicated on 9/10/2023 they witnessed Resident				process has been completed	ior		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/12/2023 155242 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4301 N WALNUT ST SIGNATURE HEALTHCARE OF MUNCIE MUNCIE, IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE D taking ice from the ice chest in the clean utility. the current population, completed CNA 14 started yelling at the resident. The on 9/26/23, with no other issues resident was in a wheelchair and CNA 14 pulled identified during the him out of the clean utility room. The resident got interview/resident assessment angry and they resident and CNA 14 exchanged process. An Ad Hoc QAPI inappropriate words. The resident punched RN meeting was held on 9/27/23 with 11 in the stomach. It was unknown if the punch the Medical Director and QAPI was deflected. CNA 14 the cup of ice and shoved Team. The facility staff have been it in the resident's direction and the ice fell to the re-educated on abuse prohibition, floor. CNA 14 walked away. The resident went to to include verbal abuse. his room. The incident was witnessed by at least It is the responsibility of the facility 2 residents and other staff members. RN 11 could staff to uphold the abuse not remember the names of the other staff prohibition policy and procedure members. RN 11 did not report the incident. "I and to refrain from swearing and did not know I had to report this kind of thing, No yelling while working in the one told me I had to report it." facility. The Director of Nursing, Assistant Director of Nursing, Unit Review of RN 11's education record indicated the Manager, Shift Supervisor, Clinical staff member received abuse reporting education Consultant, and/or the on 6/29/2023. Administrator will be responsible to interview staff on abuse During an interview on 9/12/2023 at 9:26 a.m., prohibition, including if there had CNA 12 indicated on 9/10/2023, they heard CNA been any situation not reported 14 tell Resident D to get out of the "f__ king ice". immediately to the Abuse CNA 14 continued to yell at Resident D and Coordinator 3 times a week for (4) continued to use inappropriate language. CNA 12 four weeks, two times weekly for indicated they should have reported the incident (4) four weeks; weekly for (4) four to the Administrator but did not. CNA 12 weeks; then monthly for three indicated they did report the incident to RN 11. months. Any issues identified will be immediately corrected, 1:1 A current policy, dated 5/27/2016 and last re-education completed for reviewed on 10/17/2022, titled "Abuse, Neglect stakeholder as identified, up to and Misappropriation of Property" was provided and including disciplinary action by the DON on 9/11/23 at 9:40 a.m., and indicated as determined necessary by the the following: Administrator and Director of " Policy Statement It is the organization's Nursing. intention to prevent the occurrence of abuse, The Administrator will review the neglect, exploitation, injuries of unknown origin, audits completed on a weekly and misappropriation of resident property, and to basis. Results of the reviews will assure that all alleged violations of federal or State be forwarded to the Quality

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

PRINTED: 10/03/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155242	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		00	(X3) DATE SURVEY COMPLETED 09/12/2023		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP COD 4301 N WALNUT ST MUNCIE, IN 47303					
(X4) ID PREFIX TAG	S) ID SUMMARY STATEMENT OF DEFICIENCIE EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLE		(X5) COMPLETION DATE	
	1. Every Stakeholder shall immediately report any "allegation of abuse," "injury of unknown origin," or "suspicion of crime," as those terms are defined above, to the Facility Administrator or designee as assigned by the facility administrator in his/her absence Reporting Guidelines: Any abuse allegation must be reported to State within 2 hours from the time the allegation was received" This federal tag relates to Complaint IN00417257.				10/10/23. Audit documentation will continue to be submitted to the QAPI committee for review to ensure compliance goals. QAPI committee reserves the to modify or extend monitoring times according to outcomes. The Administrator is responsib for the oversight of this plan to ensure ongoing compliance.	rand right		

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