PRINTED: 03/19/2024

	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155242		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/22/2024	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			•	4301 N	ADDRESS, CITY, STATE, ZIP COD I WALNUT ST IE, IN 47303		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE CO	
E 0000 Bldg	conducted by the Ir accordance with 42 Survey Date: 02/2: Facility Number: 0 Provider Number: AIM Number: 100/2 At this Emergency Signature Healthca compliance with Er Requirements for N Participating Provides 483.73. The facility census of 134 at the	2/24 00146 155242	E 0	000	It is the practice of this providensure that federal participation requirements for nursing hom participating in Medicare &/or Medicaid programs are met in accordance with federal and slaw. Signature HealthCARE of Mu (SCHM) respectfully requests this CMS-2567 Plan of Correction be considered the Letter of Credible Allegatic Compliance and requests a d review in lieu of a post-survey review on, or after March 8, 2	on es state ncie that on of esk	
K 0000							
Bldg. 01	Licensure Survey v	000146	K 0	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. Signature HealthCARE of Mu (SCHM) respectfully requests	on es state	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

compliance with Requirements for Participation in

At this Life Safety Code survey, Signature

Healthcare of Muncie was found not in

AIM Number: 100291200

TITLE (X6) DATE

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

Eric P. Ahlbrand **CEO-Administrator** 03/18/2024

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COM			COMPL	ETED	
155242		B. WING 02/22			2024		
			╙┯	CTDEET A	DDDFGG CITY CTATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
CICNATI		OF MUNCIF			WALNUT ST		
SIGNATO	JRE HEALTHCARE	OF MUNCIE		MONCI	E, IN 47303		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Medicare/Medicaid,	, 42 CFR Subpart 483.90(a),			review on, or after March 8, 20	24.	
	Life Safety from Fir	re and the 2012 edition of the					
	National Fire Protec	ction Association (NFPA) 101,					
	Life Safety Code (L	SC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	•	ity was determined to be of					
		ion and was fully sprinklered.					
	-	re alarm system with smoke					
		ridors, areas open to the					
		y operated smoke detectors in					
		g rooms. The facility has a					
		had a census of 134 at the					
	time of this survey.						
	All areas where the	residents have customary					
	access were sprinkle	ered. All areas providing					
	facility services wer	re sprinklered.					
	Quality Review con	npleted on 02/26/24					
K 0281	NFPA 101						
SS=E	Illumination of Mea	ans of Egress					
Bldg. 01	Illumination of Mea	•					
_		ans of egress, including exit					
		nged in accordance with 7.8					
		r continuously in operation					
	or capable of auto	matic operation without					
	manual intervention	on.					
	18.2.8, 19.2.8						
		on and interview, the facility	K 02	81	/p>		03/08/2024
		egress lighting for 1 of 8 exit					
	_	s arranged so the failure of			What corrective action(s) will		
		fixture would not leave the area			be accomplished for those		
		.8.1.4 requires illumination shall			residents found to have been	1	
	-	that the failure of any single			affected by the deficient		
		ot result in an illumination			practice: new egress lighting v		
	level of less than 0.2	_			installed outside of the 900 Ha		
	-	is deficient practice could			exit door, illuminating the area		
	affect 15 clients and	staff using the 900 Hall exit.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
155242		B. WING		02/22/2024		
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	ZR.		N WALNUT ST		
SIGNATI	URE HEALTHCAR	E OF MUNCIE		DIE, IN 47303		
01011711		L OT WORKER		7.000	<u> </u>	
(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		
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	F' 1' ' 1 1			How other residents having		
	Findings include:			potential to be affected by the	I	
	Događ on obsomjet	ion with the Dlant Manager		same deficient practice will		
		ion with the Plant Manager at 02:35 p.m., the exit means of		identified and what corrective	/e	
	1 '	n the 900 Hall exit did not have		action(s) will be taken: the SHCM Plant Operations team	النبدد	
	1 -	sed on interview at the time of		ensure ALL egress lighting is	I	
	_	M agreed there was no light		functional and illuminating pe		
	source outside of t	-		Preventive Maintenance (PM)	I	
	Source outside of t	ne 500 Han exit.		program and change/repair as		
	This finding was r	eviewed with the Administrator		needed.		
	and PM during the			noodod.		
				What measures will be put in	nto	
	3.1-19(b)			place and what systemic		
				changes will be made to		
				ensure that the deficient		
				practice does not recur: the		
				SHCM Plant Operations team		
				ensure ALL egress lighting is	II.	
				functional and illuminating pe	II.	
				Preventive Maintenance prog	II.	
				and change/repair as needed		
				How the corrective action(s)		
				will be monitored to ensure		
				deficient practice will not		
				recur: The monitoring of this		
				specific requirement is a part	of	
				the SHCM PM program and		
				executed monthly. Relative to	this	
				specific requirement, the Plan		
				Operations team will inspect f	for	
				operational effectiveness DAI	LY	
				(on business days) for two (2)		
				weeks (OR until substantial		
				compliance is achieved) and	then	
				monthly per standard PM		
				program. The entire PM progr	ram	
				is part of the agenda of the		
				monthly Safety Committee,		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155242		A. BUILDING	01	COMPLETED 02/22/2024	
		B. WING			
	PROVIDER OR SUPPLIER		4301 N	ADDRESS, CITY, STATE, ZIP COD WALNUT ST E, IN 47303	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				chaired by the Plant Operation Director. Monthly Safety Committee minutes are review in the monthly QAPI meeting chaired by the CEO. Corrective action needed to ensure compliance will be addressed immediately.	ved
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR	supply source RKS information on non-required or partial er system.			
	Based on record rev failed to maintain 1 accordance with 19 14.2.1 states except 14.2.1.4 an inspectic conditions shall be opening a flushing of main and by remov	oriew and interview, the facility of 2 sprinkler systems in .3.5.3. NFPA 25, 2011 Edition, as discussed in 14.2.1.1 and on of piping and branch line conducted every 5 years by connection at the end of one ing a sprinkler toward the end for the purpose of inspecting	K 0353	="" p=""> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The 5-Year Internal Inspection of Sprinkler Piping a Valves was scheduled for Mar	1 and

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for the presence of foreign organic and inorganic

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7, 2024 previous to LSC survey.

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>01</u>		01	COMPLETED		
155242		B. WING 02/22/2024			/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			WALNUT ST		
SIGNATI	JRE HEALTHCARE	OF MUNCIE			E, IN 47303		
SIGNATO	ONE HEALTHOAKE	- OI WONOIL		MONCH	L, IIV 77 000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
		ient practice could affect all			Ryan Fire Protection, Inc.		
	occupants.				performed inspection as		
					scheduled and the report is		
	Findings include:				attached. Noted east dry syste		
	D1 1	si sana ansikla Alas Dlassa N.5			deficiency scheduled for resol	ution	
		view with the Plant Manager			on March 15, 2024.		
	` '	at 11:20 a.m., the internal			Have other registers to be size of	th a	
		g documentation from Koorsen for the West System, dated			How other residents having to		
	-	or the west System, dated ocument that there was no			potential to be affected by the same deficient practice will to		
		material observed or if flushing			identified and what correctiv		
		ternal pipe inspection for the			action(s) will be taken: Allege		
		eted the same day by Koorsen			deficiency has the potential to		
		s no significant foreign			affect residents on the east en		
		no flushing needed. Based on			facility. Ryan Fire Protection, I		
		e of record review, the PM			performed the 5-year inspection		
		inspection documentation for			scheduled and required (repor		
	-	system was incomplete as it			attached). Noted east dry syst		
	_	ernal observation or if the			deficiency scheduled for resol		
	system needed flusl				on March 15, 2024.		
	-	-			, -		
	This finding was re	viewed with the Administrator			What measures will be put in	ito	
	and PM at the exit of				place and what systemic		
					changes will be made to		
	3.1-19(b)				ensure that the deficient		
					practice does not recur: The		
					5-Year Internal Inspection of		
					Sprinkler Piping and Valves		
					requirement is acknowledged	and	
					subsequent repairs will be		
					completed as required per		
					standard Preventive Maintena	nce	
					(PM) program.		
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur: The monitoring of this	•	
					specific requirement is a part	TC	
			1		the SHCM PM program and		1

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155242	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	E SURVEY PLETED 2/2024
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP	COD	
SIGNATU	JRE HEALTHCARE	OF MUNCIE		N WALNUT ST FIE, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 0363 SS=D Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary soliammable or com Clearance between	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain		executed monthly. Respecific requirement, Operations team will operational effectiven WEEKLY for one (1) until substantial compachieved) and then emonths per standard as well as state and for requirements. The emprogram is part of the the monthly Safety Cochaired by the Plant Obirector. Safety Comminutes are reviewed monthly QAPI meeting the CEO. Corrective at to ensure compliance addressed immediates.	the Plant inspect for ness month (OR oliance is very three (3) PM program rederal ntire PM e agenda of ommittee, Operations mittee d in the ng chaired by action needed e will be	

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	X3) DATE SURVEY	
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
155242		B. WING 02/22/2024			2024			
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			WALNUT ST			
SIGNATI	JRE HEALTHCARE	OF MUNCIE			E, IN 47303			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ГЕ	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		with 7.2.1.9 are permissible						
	1 .	device capable of keeping						
		hen a force of 5 lbf is						
	1	no impediment to the						
	_	rs. Hold open devices that						
		door is pushed or pulled are						
	1 '	ed protective plates of						
		re permitted. Dutch doors						
	1	6 are permitted. Door						
		beled and made of steel or compliance with 8.3,						
	unless the smoke							
		fire window assemblies are						
	l •	n sprinklered compartments						
		ctions in area or fire						
		s or frames in window						
	assemblies.	o or mannes in window						
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,						
		(S details of doors such as						
		ngs, automatics closing						
	devices, etc.	ngs, automatics closing						
		on and interview, the facility	K 0	363	/p>		03/08/2024	
		orridor door was provided with	15.0	505	/ P		03/00/2027	
		r keeping the door closed, had			What corrective action(s) wil			
		losing, latching and would			be accomplished for those	-		
	_	f smoke. This deficient			residents found to have beer	1		
		et 2 residents in resident room			affected by the deficient			
	702.				practice: Room 702 door was			
					repaired and functional per			
	Findings include:				requirement.			
		on with the Plant Manager			How other residents having t	he		
	, ,	at 01:45 p.m., the corridor door			potential to be affected by th			
		room 702 would not close and			same deficient practice will b			
		when tested. Based on			identified and what corrective	е		
		e of observation, the PM			action(s) will be taken: the			
		door to room 702 would not			SHCM Plant Operations team	will		
	close and latch into	the door frame and that he			ensure room doors meet the			

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, , ,		r í		ONSTRUCTION 01	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			UILDING	COMPLETED		
155242		B. WING 02/22/2024				
NAME OF P	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD	
					WALNUT ST	
SIGNATU	JRE HEALTHCARE	OF MUNCIE		MUNCI	E, IN 47303	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	has ordered a new d	loor to replace it.			requirement and change/repair needed.	ir as
	The finding was rev	viewed with the Administrator			needed.	
	and PM during the				What measures will be put ir	nto
	C				place and what systemic	
	3.1-19(b)				changes will be made to	
					ensure that the deficient	
					practice does not recur: the	
					SHCM Plant Operations team ensure room doors meet the	WIII
					requirement and change/repair	ir as
					needed. Relative to this specif	
					requirement, Plant Operations	I
					team inspects doors as a part	I
					the Preventive Maintenance	
					program and change/repair as	5
					needed.	
					How the corrective action(s)	
					will be monitored to ensure t	
					deficient practice will not	
					recur: The monitoring of this	
					specific requirement is a part	of
					the SHCM PM program and	
					executed monthly. Relative to	
					specific requirement, the Plan Operations team will inspect for	I
					operational effectiveness of ro	
					doors on 700 unit DAILY (on	·
					business days) for two (2) wee	eks
					(OR until substantial complian	I
					is achieved) and then monthly	
					standard PM program. The en	
					PM program is part of the age	I
					of the monthly Safety Commit chaired by the Plant Operation	
					Director. Monthly Safety	15
					Committee minutes are review	ved
					in the monthly QAPI meeting	
					chaired by the CEO. Corrective	re

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STATEMEN'	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>01</u>	COMPLETED		
	155242 B. WING			02/22/2024				
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE				STREET ADDRESS, CITY, STATE, ZIP COD 4301 N WALNUT ST MUNCIE, IN 47303				
(X4) ID	SUMMARY S	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 APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					action needed to ensure compliance will be addressed immediately.			

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