STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155242	A. BUILDING -- B. WING	02/22/2024

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/22/24 Facility Number: 000146 Provider Number: 155242 AIM Number: 100291200 At this Emergency Preparedness survey, Signature Healthcare of Muncie was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 140 and had a census of 134 at the time of this survey. Quality Review completed on 02/26/24	E 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 March 8, 2024.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/22/24 Facility Number: 000146 Provider Number: 155242 AIM Number: 100291200 At this Life Safety Code survey, Signature Healthcare of Muncie was found not in compliance with Requirements for Participation in	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric P. Ahlbrand	CEO-Administrator	03/18/2024

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type VIII construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 140 and had a census of 134 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/26/24		review on, or after March 8, 2024.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the egress lighting for 1 of 8 exit means of egress was arranged so the failure of any single lighting fixture would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect 15 clients and staff using the 900 Hall exit.	K 0281	/p> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** new egress lighting was installed outside of the 900 Hall exit door, illuminating the area.	03/08/2024

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	Findings include: Based on observation with the Plant Manager (PM) on 02/22/24 at 02:35 p.m., the exit means of egress outside from the 900 Hall exit did not have a light fixture. Based on interview at the time of observation, the PM agreed there was no light source outside of the 900 Hall exit. This finding was reviewed with the Administrator and PM during the exit conference. 3.1-19(b)		**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:** the SHCM Plant Operations team will ensure ALL egress lighting is functional and illuminating per Preventive Maintenance (PM) program and change/repair as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** the SHCM Plant Operations team will ensure ALL egress lighting is functional and illuminating per Preventive Maintenance program and change/repair as needed. **How the corrective action(s) will be monitored to ensure the 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 Plant Operations team will inspect for operational effectiveness DAILY (on business days) for two (2) weeks (OR until substantial compliance is achieved) and then monthly per standard PM program. The entire PM program is part of the agenda of the monthly Safety Committee,	

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			chaired by the Plant Operations Director. Monthly Safety Committee minutes are reviewed in the monthly QAPI meeting chaired by the CEO. Corrective action needed to ensure compliance will be addressed immediately.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 2 sprinkler systems in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic	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 and Valves was scheduled for March 7, 2024 previous to LSC survey.	03/23/2024

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	material. This deficient practice could affect all occupants. Findings include: Based on record review with the Plant Manager (PM) on 02/22/24 at 11:20 a.m., the internal inspection of piping documentation from Koorsen Fire and Security for the West System, dated 05/15/19, did not document that there was no significant foreign material observed or if flushing was needed. The internal pipe inspection for the East system completed the same day by Koorsen stated that there was no significant foreign material found and no flushing needed. Based on interview at the time of record review, the PM agreed the internal inspection documentation for the West sprinkler system was incomplete as it did not state the internal observation or if the system needed flushing. This finding was reviewed with the Administrator and PM at the exit conference. 3.1-19(b)		Ryan Fire Protection, Inc. performed inspection as scheduled and the report is attached. Noted east dry system deficiency scheduled for resolution on March 15, 2024. **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:** Alleged deficiency has the potential to affect residents on the east end of facility. Ryan Fire Protection, Inc. performed the 5-year inspection as scheduled and required (report is attached). Noted east dry system deficiency scheduled for resolution on March 15, 2024. **What measures will be put into place and what systemic changes will be made to 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 Maintenance (PM) program. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The monitoring of this specific requirement is a part of the SHCM PM program and	

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			executed monthly. Relative to this specific requirement, the Plant Operations team will inspect for operational effectiveness WEEKLY for one (1) month (OR until substantial compliance is achieved) and then every three (3) months per standard PM program as well as state and federal requirements. The entire PM program is part of the agenda of the monthly Safety Committee, chaired by the Plant Operations Director. Safety Committee minutes are reviewed in the monthly QAPI meeting chaired by the CEO. Corrective action needed to ensure compliance will be addressed immediately.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered			

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	doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 corridor door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in resident room 702. Findings include: Based on observation with the Plant Manager (PM) on 02/22/24 at 01:45 p.m., the corridor door to resident sleeping room 702 would not close and latch into the frame when tested. Based on interview at the time of observation, the PM agreed the corridor door to room 702 would not close and latch into the door frame and that he	K 0363	/p> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Room 702 door was repaired and functional per requirement. **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:** the SHCM Plant Operations team will ensure room doors meet the	03/08/2024

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	has ordered a new door to replace it. The finding was reviewed with the Administrator and PM during the exit conference. 3.1-19(b)		requirement and change/repair as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** the SHCM Plant Operations team will ensure room doors meet the requirement and change/repair as needed. Relative to this specific requirement, Plant Operations team inspects doors as a part of the Preventive Maintenance program and change/repair as needed. **How the corrective action(s) will be monitored to ensure the 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 Plant Operations team will inspect for operational effectiveness of room doors on 700 unit DAILY (on business days) for two (2) weeks (OR until substantial compliance is achieved) and then monthly per standard PM program. The entire PM program is part of the agenda of the monthly Safety Committee, chaired by the Plant Operations Director. Monthly Safety Committee minutes are reviewed in the monthly QAPI meeting chaired by the CEO. Corrective	

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			action needed to ensure compliance will be addressed immediately.	