| 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 _____ | R-C 06/23/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 000} | INITIAL COMMENTS | {F 000} | | |

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00353693 completed on May 17, 2021.

Complaint IN00353693 - Corrected.

Survey date: June 23, 2021

Facility number: 000146
Provider number: 155242
AIM number: 100291200

Census Bed Type:
SNF/NF: 122
Total: 122

Census Payor Type:
Medicare: 10
Medicaid: 77
Other: 35
Total: 122

Signature Healthcare of Muncie was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00353693.

Quality review completed on June 23, 2021.

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