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 _____	C 08/10/2021

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 This visit was for the Investigation of Complaint IN00359366. Complaint IN00359366 - Unsubstantiated due to lack of evidence. Survey dates: August 10, 2021 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 116 Total: 116 Census Payor Type: Medicare: 13 Medicaid: 81 Other: 22 Total: 116 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 Investigation of Complaint IN00359366. Quality review completed on August 16, 2021.	F 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.