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	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Muncie	4301 N Walnut St Muncie, IN 47303

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32663 Based on interview and record review, the facility failed to ensure effective monitoring and services were provided when Resident B requested to be transferred to the hospital after experiencing acute abdominal pain with nausea for 1 of 3 residents reviewed for change in condition. This deficient practice resulted in the resident a delay in treatment that required emergent hospitalization for treatment of a perforated bowel with sepsis (severe infection throughout body), a hemicolectomy (a surgical intervention to permanently open the bowel), intravenous (IV) antibiotic therapy via a PICC (a central intravenous line) line, and a permanent colostomy. Findings include: Resident B's closed clinical record was reviewed on 4/15/24 at 11:00 a.m. Diagnoses included paroxysmal atrial fibrillation, fracture of lower end of right femur, acute embolism and thrombosis of deep veins of right lower extremity, rheumatoid arthritis, type 2 diabetes mellitus, and constipation. The most recent admission Minimum Data Set (MDS) assessment, dated 11/29/23, indicated Resident B was cognitively intact, made herself understood, and understood others. She had not experienced a change in mental status. She received medications at high-risk for side effects, including diuretics and opioids. She was dependent on others for toileting, and was frequently incontinent of bowel. The resident's December 2023 physician orders included, but were not limited to, the following: Observe resident closely for significant common side effects related to opioid medication use such as sedation, dizziness, nausea/vomiting, constipation, physical dependence, tolerance, respiratory depression, delayed gastric emptying, hyperalgesia (over-medicating), immunologic and hormonal dysfunction, muscle rigidity, and myoclonus (muscle jerking) every shift (dated 11/23/23), hydrocodone-acetaminophen (opioid pain medication) 10-325 mg, one tablet orally for pain every 4 hours as needed (order date 11/22/23), furosemide (diuretic) 20 mg, three tablets to equal 60 mg once daily (ordered 11/22/23-12/1/23), furosemide 40 mg, one tablet twice daily (ordered 12/1/23-2/2/24), (continued on next page)

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.

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	observe resident closely for significant common side effects related to diuretic medication use such as dark urine, irregular heartbeat, fatigue lethargy, convulsions, nausea/vomiting, diarrhea/constipation, cramping, and weakness (order date 11/22/23), and bisacodyl (laxative) 10 mg suppository once a day as needed for constipation (order date 12/22/23). The resident's Medication Administration Record (MAR) for December 2023 indicated the following: Hydrocodone-acetaminophen 10-325 mg was given 55 times between 12/1/23 and 12/24/23 for chronic pain and recent femur fracture, the side effect of constipation was documented on 12/22/23 for opioid use, and a bisacodyl suppository was given on 12/24/23 at 9:33 p.m. The resident's December 2023 bowel movement record indicated Resident B had a medium, formed bowel movement on 12/20/23. A nurse progress note, dated 12/22/23 at 1:11 p.m., indicated the resident complained of constipation. The resident's abdomen was soft and not distended, with active bowel sounds heard in all quadrants. The physician was informed and a new order for bisacodyl suppositories once a day as needed was received. A Change in Condition form was initiated for constipation and indicated the system of concern was gastrointestinal related to constipation. A nurse progress note, dated 12/23/23 at 6:34 p.m., indicated the resident complained of pain and was medicated with an as-needed medication for constipation, with no results. The progress note lacked a pain assessment, did not identify the area of pain, and lacked an abdominal assessment. A nurse progress note, dated 12/23/23 at 6:39 p.m., indicated the resident continued to complain of pain with no bowel movement. The resident's December 2023 bowel movement record indicated two large bowel movements on 12/23/23. The consistency of the bowel movements was not indicated. The resident's December 2023 meal intake report indicated she did not eat lunch or dinner on 12/23/23 and 12/24/23. A nurse progress note, dated 12/24/23 6:34 a.m., indicated the resident complained of pain and experienced two bouts of yellowish-green emesis (vomiting). The resident was medicated with an as needed Zofran (antiemetic). The progress note lacked a pain assessment, did not identify the area of pain, and lacked an abdominal assessment. A nurse progress note, dated 12/25/23 at 5:00 a.m., indicated the resident was found having black coffee ground appearing emesis and severe abdominal pain. The as needed medications were documented as ineffective. The resident requested to be sent to the emergency room . The resident rated the abdominal pain as 9 out of a scale of 1-10. The physician was made aware, and an order to send the resident to the emergency room for evaluation and treatment was received. 911 was called for transport. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A late-entry nurse progress note, dated 12/25/23 at 5:23 a.m., for 12/24/23 at 9:31 p.m., indicated the resident complained of nausea and vomiting, and abdominal pain. The resident indicated the pain had started a few days prior and she had been trying to digitally remove stool by herself. The resident requested as needed medication for constipation and nausea/vomiting. The medication was administered. The progress note lacked an abdominal assessment. Review of assessments and progress notes for 12/23/23 after 1:11 p.m. through 12/24/23 before 5:00 a.m. lacked indication of physician notification and abdominal assessments. The hospital emergency room note, dated 12/25/23 at 6:23 a.m., indicated the resident presented with the chief complaint of constipation and vomiting. The resident complained of abdominal pain and indicated her last bowel movement was one week prior. She had a history of constipation issues, but indicated it had never been this bad. She reported she had attempted to remove the stool herself, and the night prior, the facility nurse had tried to digitally remove an impaction (bowel movement stuck in or near the rectum). The abdominal pain had started 3 days prior and was rated as a 10 on a scale of 1-10. The resident had not been taking stool softeners while taking pain medications. Assessment of the abdomen indicated it was soft and mildly distended with hypoactive bowel sounds. The resident was alert and oriented to person, place, and time. The abdominal CT (radiology imaging) indicated moderate pneumoperitoneum (air or gas in the abdominal cavity) with concerns of bowel perforation. Surgical intervention was initiated. The resident was also determined to be septic. An inpatient hospital discharge summary, dated 1/30/24, indicated the resident had been admitted for peritoneal infection after a perforated bowel. The resident had been found to be septic and required laparotomy washout (surgical cleaning of abdomen) and left hemicolectomy with end colostomy (an opening in the abdomen for the intestine to allow elimination of bowel contents). A progress note, dated 2/2/24 at 12:40 p.m., indicated the resident was readmitted to the facility from the hospital. The resident arrived with a PICC line for I.V. antibiotic administration and a colostomy bag. During an interview, on 4/15/24 at 11:53 a.m., Resident B's family member indicated they had been visiting the resident on 12/24/23. The resident was complaining of abdominal pain and requested to be sent to the hospital. The resident was sent to the hospital the next day and had to have surgery for a colostomy. During an interview on 4/15/23 at 1:16 p.m., RN 1 indicated, on 12/22/24, Resident B had complained of constipation. An order for medication was received from the Nurse Practitioner (NP). RN 1 did not administer the medication since it was the end of the shift, and passed the information on to the oncoming shift. RN 1 indicated Resident B had been digitally removing stool from the rectum themselves. During an interview, on 4/15/24 at 1:32 p.m., CNA 2 indicated, on 12/24/24, during the day shift ending at 6:00 p.m., the family of Resident B had requested the resident be sent to the hospital. CNA 2 indicated the resident was not acting like herself; she was sweaty and screaming out, which was unusual for her. The CNA reported the request to LPN 3 and was told LPN 3 thought the resident was overreacting, and LPN 3 was unable to send the resident out without permission. CNA 2 did not report this information to another nurse. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 4/15/24 at 1:53 p.m., Unit Manager 4 indicated Resident B had previously reported a history of constipation and had never really had regular bowel movements. During an interview, on 4/15/24 at 2:38 p.m., the Weekend Supervisor indicated Resident B was sent to the hospital after she started vomiting. The Weekend Supervisor denied seeing the resident in any acute distress. During an interview, on 4/15/24 at 2:56 p.m., the Weekend Supervisor indicated she had been unaware of the resident requesting to be sent out to the hospital. The Weekend Supervisor indicated if she had known Resident B had asked to go the the hospital, she would have sent the resident to the hospital. During an interview, on 4/16/24 at 10:16 a.m., LPN 3 indicated she did not know Resident B, as she had never taken care of her before 12/24/23. The resident was bedridden and was placed on the bedpan and bedside commode several times and never had any results. The resident also indicated she felt like she was going to vomit and requested an emesis basin. The resident requested to be sent to the hospital. LPN 3 reported this to the Weekend Supervisor and was told this was normal behavior for the resident and not to send her out. LPN 3 indicated the resident was in pain and was administered pain medication. She did not document these interactions or observations in the clinical record. She did not notify the physician of the resident's condition, nor the resident's desire to be sent to the hospital. During an interview, on 4/16/24 at 1:03 p.m., the Regional Care Consultant indicated if the resident requested to be sent to the hospital, it should have been documented in the clinical record and the physician should have been notified and the resident sent out. Per the facility bowel protocol, if a resident had not had a bowel movement in three days (72 hours) the protocol would have been initiated. RN 99, who worked 12/25/23 and was assigned care of Resident B and sent resident to the hospital, declined interview on 4/26/24. A current facility policy, dated 9/15/23 and titled Notification of Change of Condition, was provided by the Unit Manager on 4/16/24 at 12:45 p.m. The policy indicated the following: .Policy .To ensure appropriate individuals are notified of changes in condition. Guidelines 1. The facility must inform the resident, consult with the resident's physician; and notify consistent with his or her authority, the resident representative(s) when there is: a. An accident involving the resident which results in an injury and has the potential for requiring physician intervention, b. A significant change in the resident's physical, mental, or psychological status. c. A need to alter treatment significantly. (continued on next page)

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