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	07/05/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 Based on observation, interview and record review, the facility failed to ensure a resident was free from verbal abuse from a staff member for 1 of 3 residents reviewed for abuse. (Resident F) Findings include: During an interview with Resident L, on 7/3/24 at 11:03 a.m., she indicated she witnessed CNA 6 tell Resident F that the resident needed to get out of the facility. She didn't need to live there, and needed to move in with her ex-husband and mooch off him. The CNA also told Resident F that her grandkids didn't love her. During an interview with Resident K, on 7/3/24 at 11:58 a.m., she indicated she had witnessed CNA 6 arguing with Resident F because she intentionally did not pass ice to Resident F. Resident F reported it, and CNA 6 told Resident F that she was a bully and she needed to move back in with her husband and that her children only wanted her for her money. During an interview with Resident F, on 7/3/24 at 12:29 p.m., she indicated CNA 6 would not give her ice water and told her that she had to get her own, although she was not supposed to be in the area where the ice was located. This was also the same with linens. She had been living at the facility for six months and she had to change her own linens and retrieve the linens from the linen closet. She reported that she felt CNA 6 intentionally did not pass ice water to her. After she reported it, CNA 6 followed her down the hall and told Resident F that she got her into trouble, and she needed to find another place to live. She needed to go home to live with her husband and the only reason her children and grandchildren came to visit her in the facility was for her money. She responded with negative comments related to CNA 6's personal life. Resident F rolled up to CNA 6 in her wheelchair and Resident F's knees touched CNA 6. CNA 6 began to yell that she wanted Resident F to be arrested and sent to jail. RN 12 was present and separated them. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator, on 7/3/24 at 4:18 p.m., he indicated Resident F came to his office with concerns regarding CNA 6 not giving her ice water and felt CNA 6 had singled her out. CNA 6 had seen Resident F come from his office and approached Resident F and said to her You told on me. Later, Resident F, CNA 6, and RN 12 were in his office, at some point CNA 6 claimed Resident F slammed into her with the wheelchair and Resident F indicated CNA 6 was on her phone rather than working. CNA 6 felt Resident F bullied staff. The Administrator decided he needed to meet with them individually rather than them talking over each other. He asked CNA 6 to leave, and she was suspended pending the investigation. He was waiting on the Human Resource (HR) to review the situation. His biggest concern was that CNA 6 had an inappropriate verbal altercation with a resident. They are supposed to be equipped for that type of behavior; staff could not and should not engage. An altercation could turn into verbal abuse or worse. CNA 6 and Resident F were virtually separated immediately. RN 12 told CNA 6 and Resident F to go to the Administrator's office. During an interview with CNA 6, on 7/3/24 at 4:35 p.m., she indicated the Scheduler had told her that Resident F wanted CNA 6 moved off her hall and wanted to get her fired. CNA 6 asked Resident F about it. CNA 6 told Resident F that her grandkids don't come to see her because she didn't have any money to give to them. She knew she shouldn't have said that to her. Resident F verbally assaulted her by making a comment about her personal life. Resident F was in her wheelchair and ran over her toes and ran into her legs, which left bruising on her legs. When they were all in the Administrator's office, she told him she was going to call the police on Resident F and have her arrested for battery. Resident F's clinical record was reviewed on 7/3/24 at 12:19 p.m. Diagnoses include peripheral vascular disease, muscle weakness (generalized), need for assistance with personal care, difficulty in walking, not elsewhere classified, major depressive disorder, single episode, anxiety disorder, and unspecified lack of coordination. Her orders included alprazolam (treat anxiety) 0.5 mg (milligram) four times daily, trazodone (treat depression) 75 mg daily, and venlafaxine (treat depression) 225 mg daily. A quarterly Minimum Data Set (MDS), dated [DATE], indicated she was cognitively intact. She required supervision for bed mobility, transfers and toilet use. No behaviors were exhibited. Her clinical record lacked a care plan and nurses notes related to the incident with CNA 6. A current facility policy, titled Abuse, Neglect and Misappropriation of Property, provided by the Nurse Consultant on 7/3/24 at 4:51 p.m., indicated the following: .Definitions .Verbal abuse is the use of any oral, written, or gestured language that includes any threat, or any frightening, disparaging or derogatory language, to residents or their families, or within hearing distance, regardless of age, ability to comprehend, or disability . This citation relates to complaint IN00438076. 3.1-27(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40241 Based on interview and record review, the facility failed to report an allegation of abuse to the State Agency in a timely manner for 1 of 3 reportable abuse allegations reviewed. Findings include: A facility reported incident indicated an allegation of verbal abuse occurred on 6/27/24 at 4:45 p.m. when Resident F alleged CNA 6 intentionally skipped providing ice water to her because CNA 6 felt Resident F could get it herself. This led to a loud verbal exchange during which angry language was used by each party. The confirmation email for the incident indicated it was submitted to the Indiana State Department of Health on 6/30/24 at 8:27 a.m. During an interview with the Administrator, on 7/3/24 at 4:18 p.m., he indicated abuse was to be reported within 24 hours unless it involved physical abuse, then it was to be reported within two hours. A current facility policy, titled Abuse, Neglect and Misappropriation of Property, provided by the Nurse Consultant on 7/3/24 at 4:51 p.m., indicated the following: .Reporting Guidelines: Any abuse allegations must be reported to State within 2 hours from the time the allegation was received Cross reference F 600. This citation relates to complaint IN00438076. 3.1-28(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 32663 Based on interview and record review, the facility failed to ensure dependent residents received showers/bed baths per the resident care plan and resident preference for 2 of 4 residents reviewed of activities of daily living. (Residents E and M) Findings include: 1. The clinical record for Resident E was reviewed on 7/5/2024 at 11:21 a.m. Diagnoses included cerebral infarction, hydronephrosis, chronic obstructive pulmonary disease, need for assistance with personal care, muscle weakness, dysphagia, anxiety disorder, depressive disorder, osteoarthritis, hearing loss, and chronic pain syndrome. The most recent quarterly Minimum Data Set (MDS) assessment indicated Resident E was cognitively intact and required supervision and touch assistance for showers and shower transfers. Review of the facility shower schedule indicated Resident E was scheduled for showers on Mondays, Thursdays and Saturday evenings. Review of Resident E's care plans indicated bathing preferences had not been assessed and recorded. Review of Resident E's care plans indicated a history of refusal for treatment/care as evidenced by refusal for as needed prune juice, labs and medications for bowel movements. Review of the clinical record indicated from 6/5/24 through 7/4/24, Resident E received four showers. The resident was scheduled for 12 showers during the same 29-day period. During an interview on 7/5/24 at 10:39 a.m., Resident E indicated they preferred showers. The resident indicated showers were scheduled on Mondays, Thursdays and Saturdays in the evening. Sometimes they (staff) told her they did not have time for her showers. This happened most of the time. I usually have to do it myself. During an interview on 7/5/24 at 12:34 p.m., CNA 12 indicated Resident E reminded staff off her shower days. CNA 12 indicated they worked 6:00 a.m. to 6:00 p.m. and attempted to get at least one of the evening showers done in addition to the day shift showers. 40339 2. During an interview on 7/3/24 at 11:22 a.m., Resident M indicated she had not been getting a complete bed bath on schedule for some time. Her hair had not been washed for at least three weeks. She received quick wash-ups, when staff change her brief. She preferred a complete bed bath when she got into bed at night due to her being transferred using a mechanical life and not wanting to transfer more than she had to. The clinical record for Resident M was reviewed on 7/5/24 at 10:14 a.m. Diagnoses included right heart failure, atrial fibrillation, morbid obesity, and need for assistance with personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent quarterly MDS assessment, dated 4/5/24, indicated the resident was cognitively intact and was dependent on staff for bathing. Review of the facility shower schedule indicated Resident M was scheduled for a complete bed bath on Tuesday, Thursday and Saturday. A current health care plan, updated 4/16/24, regarding ADL (activities of daily living) functional status included Resident does not like to have showers, is deathly afraid of water in her face. An approach indicated staff to provide assistance as needed with all ADL care to ensure daily needs were met. Review of the resident's ADL bathing record indicated from 6/5/24 through 7/5/24, Resident M received two complete bed baths. The resident was scheduled for 13 complete bed baths during that 30-day period. During an interview on 7/3/24 at 11:41 a.m., QMA 13 indicated day shift got their assigned showers completed. Evening shift did not get the assigned showers completed. Staff offered bed baths, but they did not replace getting a shower. During an interview on 7/5/24 at 11:20 a.m., CNA 7 indicated Resident M was scheduled for a complete bed bath in the evening. She had given her a partial bed bath during the day shift as part of her care. The resident had shared with her before that she had not been getting her complete bed baths. The resident had not refused care. She indicated the resident told her she preferred her bath at 9:00 p.m. when she was transferred to bed for the night. During an interview on 7/5/24 at 3:40 p.m., the Corporate Nurse Consultant indicated resident's should have their preferences met regarding time of bathing and hygiene. A current facility policy, revised 9/15/23, titled, Resident Rights, provided by the Corporate Nurse Consultant on 7/5/24 at 3:56 p.m., included the following: .Policy Statement All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility. All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life This citation relates to complaint IN00436945. 3.1-38(b)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40339 Based on interview and record review, the facility failed to ensure physician ordered medication was obtained to continue treatment for a resident for 1 of 1 residents reviewed for neglect. (Resident B) Findings include: The closed clinical record for Resident B was reviewed on 7/2/24 at 6:45 p.m. Diagnoses included anemia, nausea with vomiting, history of stroke with right side hemiplegia, and copper deficiency. The resident was admitted to the facility on [DATE] at approximately 7:00 p.m., from an acute care hospital stay. The hospital discharge orders included copper sulfate (supplement) 2 mg (milligram) daily for the duration of 30 days for anemia due to gastrointestinal blood loss. A physician hematology consultation report, dated 6/3/24, completed during the resident's acute hospital stay included the following: Copper deficiency. Start copper sulfate 2 mg orally daily, to continue even on discharge, for 1 month. The resident's physician admission orders, dated 6/7/24, included Copper Sulfate (cupric sulfate (bulk)) crystals, 2 ml (milliliter) daily for anemia due to gastrointestinal blood loss. The order was discontinued 6/7/24. A physician's order, dated 6/7/24, indicated Copper Sulfate (cupric sulfate (bulk)) crystals, 2 ml daily for anemia due to gastrointestinal blood loss. The order was discontinued 6/9/24. A physician's order, dated 6/9/24, indicated, Copper Sulfate (cupric sulfate (bulk)) crystals, 2 mg (milligrams) daily for anemia due to gastrointestinal blood loss. The order was discontinued 7/7/24. A nurse practitioner progress note, dated 6/10/24, indicated, during the resident's acute hospital stay, she had an undetectable copper level which led to the addition of Copper Sulfate 2 mg daily. A noted assessment and plan included to continue copper sulfate 2 mg once daily through July 7, 2024, for the resident's anemia. During a telephone interview on 6/5/24 at 10:43 a.m., the Pharmacy Technician indicated the order for copper sulfate was received by the pharmacy on 6/8/24 at 11:00 p.m. (52 hours after resident was admitted). This information was processed and entered for pharmacy staff on 6/9/24 at 7:00 p.m., and available to pharmacy staff on 6/10/24. She indicated the pharmacy did not have this medication in stock and an email was sent to the facilities Director of Nursing on 6/10/24 at 7:46 p.m. During an interview on 7/5/24 at 11:43 a.m., the DON indicated the copper sulfate had not been received with the rest of Resident B's medications. The nurse practitioner was notified of the delay on 6/11/24. The DON indicated the staff should have contacted the pharmacy when the medication had not arrived with the resident's other medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 6/11/24 at 10:30 a.m. as a late entry note on 6/12/24 at 10:08 a.m., indicated the facility was notified by pharmacy that the copper 2 mg supplement could not be obtained. During a telephone interview on 7/5/24 at 12:29 p.m., the Nurse Practitioner indicated she had been unaware the copper sulfate was unavailable until Monday, 6/10/24. She was aware the DON had attempted to get the copper sulfate from another vendor and finally ordered the supplement from an online source on 6/11/24. The medication needed to be administered due to the continued order from the hospital. She had not given an order to place the medication on hold. A current facility policy, dated 1/23, titled, Medication Orders Non-Controlled Medication Orders, provided by the Corporate Nurse Consultant on 7/3/24 at 4:51 p.m., included the following: .Procedures Elements of the Medication Order: .4. The prescriber shall be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not available This citation relates to complaint IN00436790. 3.1-25(a)