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	06/03/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to allow a resident to return to the facility following a hospital outpatient observation and failed to indicate supporting rationale or documentation for the discharge . (Resident C) Findings include: Resident C's clinical record was reviewed on 6/2/25 at 11:01 a.m Diagnoses included chronic congestive heart failure, chronic obstructive pulmonary disease, pressure ulcer of sacral region, chronic osteomyelitis, polyneuropathy, muscle spasm, chronic stage 3 kidney disease, opioid use, chronic pain syndrome, and depressive disorder. The resident was admitted to the facility on [DATE]. A 3/28/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident C was cognitively intact and had moderate depression. Review of Resident C's care plans indicated the resident displayed verbal aggression. The clinical record lacked a care plan for physical aggression. Review of a progress note, dated 5/1/25 at 1:35 p.m., indicated Unit Manager 1 heard Resident C yelling and using in appropriate language directed towards the Social Service Director (SSD). The Unit Manager attempted to de-escalate the situation and the resident became verbally aggressive towards her. The CCS (Corporate Clinical Support) and Therapy Director intercepted the resident and the resident became verbally aggressive towards them. The CCS called the police and the resident was taken into police custody. The resident's family and Nurse Practitioner (NP) were notified. The responding officer was unable to be reached for interview during the survey. (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an IDT Behavior Note, dated 5/15/25 at 6:20 p.m., indicated Resident C became upset after being notified he would be getting another roommate. Resident C had been involved in a verbal altercation with his previous roommate and the roommate was removed from the room. Resident C aggressively followed the SSD down the hallway and continued yelling and using inappropriate language. The Unit Manager attempted to de-escalate the situation. Resident C became agitated and began yelling profanities at the Unit Manager and making threatening remarks. The resident continued to yell at staff in the area and wheeled his wheelchair towards them. The Unit Manager notified the CCS. The CCS arrived and attempted to de-escalate the situation. Again, the resident became verbally aggressive toward the CCS and moved towards her, attempting [unspecified] harm. The police were called and arrived to place the resident in police custody. Notifications were made. The Ombudsman was also notified and informed the facility that if the resident was taken into police custody, they did not have to allow him to return to the facility. An emergency discharge was initiated and paperwork was completed. Review of a hospital discharge note, dated, 5/15/25, indicated Resident C arrived to the emergency department with an officer from the local police department. The officer reported he had been dispatched to the facility after the resident became verbally aggressive with staff. The officer reported that facility staff gave him the details of the situation and informed him Resident C had warrants for his arrest. The resident was notably upset. The officer indicated the resident had two warrants in city court for driving while suspended and failure to appear. The resident stated he had gotten into an altercation today because his previous roommate threatened to stab him three days ago, and yesterday they moved the roommate, but it was only to across the hall. The patient stated he was speaking to staff about this today because he was upset that they were not further apart and then the situation escalated. Staff reportedly told police that due to patient's aggression, they did not feel comfortable with him staying at the facility, so he was brought to emergency department for medical clearance for jail, as he would have to go to jail for the outstanding warrants. The facility did not call the emergency department to provide any further information. During an interview on 6/2/25 at 10:29 a.m., the area Ombudsman indicated, on 5/16/25, she received a phone call from the CCS regarding Resident C. The CCS indicated the resident had a verbal altercation with his roommate and the police were called. Resident C had an outstanding warrant and had been arrested and taken into police custody. The CCS asked if the resident could be discharged from the facility since he had been arrested. On 5/16/25, the Ombudsman spoke with Resident C, who indicated he was staying with his family member and that he had called the facility and was told they refused to take him back. The resident indicated he had been taken to the hospital for observation and was then released to the custody of his family member. The resident indicated he had not been arrested. On 5/28/25, the Ombudsman spoke with the responding officer, who indicated when he had been called to the facility, he was told by the CCS the resident had an outstanding warrant. The resident was taken to the hospital for examination and then released to his family member. The officer said the warrant was minor and he had been able to assist the resident in getting a new court date. On 5/28/25, the Ombudsman also spoke to staff members who voiced concern that Resident C may have been unjustly discharged . The Ombudsman called the facility Administrator with the concerns. The Administrator told the Ombudsman he would look into the incident and get back with her. The Ombudsman indicated she had not heard back from the facility. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/2/25 at 11:40 a.m., the CCS indicated, on 5/15/25, Resident C was an immediate discharge because he became hostile and attempted to harm the SSD, Unit Manager, Therapy Director, and herself. It was bad enough they had to call 911. When the police arrived, they ran his name and found out he had an outstanding warrant. The police officer told the facility Resident C was being arrested. He was taken to the hospital for an examination. The police were unable to transport him so he went via ambulance. When he left the facility, he was in police custody. The Ombudsman was called and she indicated if the resident left the facility in police custody, it would be an immediate discharge. The facility informed the hospital they would not be taking the resident back. The resident was discharged from the hospital to his sister. His sister brought him to the facility to get his belongings. He was not allowed back in the facility. The Liaison was going to go to the hospital to deliver the paperwork for the immediate discharge, but the resident was already on his way to the facility. The Liaison stayed and met the resident in the outside. The resident refused to sign the paperwork. His sister came into the facility to get his belongings. She signed the paperwork. During an interview on 6/2/25 at 1:13 p.m., CNA 3 indicated they were present during the incident on 5/15/25. Resident C was upset and yelling because the facility was going to move his old roommate across the hall from his room. He and his roommate had a verbal altercation a few days prior. The roommate had been sent out of a psychiatric evaluation. CNA 3 indicated the resident was verbally aggressive, however she never saw him being physical aggressive. During an interview on 6/2/25 at 1:23 p.m., the Liaison indicated he returned to the facility to get Resident C's inventory sheet and discharge paperwork. By the time he got it together, the resident had already left the ER. The Liaison called the resident's sister and she said they were at the facility. He brought the paperwork for the resident to sign back to the facility. The Liaison indicated at first, the resident acted like he was going to sign and then he refused and started yelling and arguing. It was already past 7:30 p.m. Eventually, the resident returned the paperwork and said he would not sign them. The resident's sister had entered the facility and the CCS had gone over the information with the sister and she signed them. During an interview on 6/2/25 at 2:22 p.m. the Therapy Director indicated, on 5/15/25 at approximately 1:00 p. m., the Unit Manager called for male assistance at the nurses station. Resident C was yelling and threatening people. The Therapy Director did not hear Resident C make any threatening comments to staff. The Therapy Director denied speaking to the resident. He watched the resident to make sure no one got hurt. The Therapy Director did not see the resident being physical aggressive anyone. The Therapy Director walked away when the police arrived. During an interview on 6/3/25 at 9:03 a.m., CNA 5 indicated she heard Resident C yelling and saw him yelling at staff at the nurses' station. She did not see the resident being physically aggressive with anyone. CNA 5 indicated she ha known the resident to verbally aggressive, but never physically aggressive. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/25 at 9:11 a.m., Unit Manager 1 indicated Resident C came into the office and threatened to harm another his old roommate and anyone they moved into his room. She tried to calm him down, got the SSD, and explained the situation to her. The SSD went to the resident's room and heard screaming and yelling. She saw the SSD was walking up the hall and resident was following her in his wheelchair, screaming. The resident threatened to kill Unit Manager 1 when she tired to calm him down. The CCS was called to the area and tried to de-escalate the situation. He started threatening her and was yelling at her. The Unit Manager thought he was going to hit them. The resident started to swing his arm, but pulled it back. The Therapy Director came up the hall and tried to de-escalate the situation. He tried talking to the resident, who was screaming at him, What are you going to do big boy? He did not make physical contact with the Therapy Director. The police showed up and they tried to talk to them. He as verbally negative with them. The officer ran the resident's name and found out he had outstanding warrants. They told him they were going to take him in. They had called an ambulance because they couldn't get his wheelchair in the police car. During an interview on 6/3/25 at 10:39 a.m. the DON indicated she was present on 5/15/25, but was no longer employed at the facility. She heard yelling and saw Resident C in his wheelchair at the nurses' station. She denied seeing the resident being physical aggressive with anyone. During an interview on 6/3/25 at 1:42 p.m., the SSD indicated she was present on 5/15/25, but was no longer employed at the facility. Resident C had told her he wanted a private room after his roommate was moved out. He got upset because he did not want a roommate and it was planned to move someone else into the room with him. Resident C became verbally aggressive. The former SSD told the resident they could continue the conversation when he stopped cursing and yelling. The resident followed her down the hallway and continued to yell and make threatening statements. The CCS came out of her office, and he started threatening her. The CCS ended up calling the police. He was not physically aggressive with the former SSD. When the police came, she was told by the CCS to leave from the area. The SSD did not talk to the police when they arrived. When she came back the next day, she as told the resident had been arrested and was not coming back to the facility. During an interview on 6/3/25 at 2:17 p.m., the resident's sister indicated, after an altercation between Resident C and his roommate, the facility moved the roommate out of the room. The facility later said they were moving another resident into his room. Resident C was upset. The police were called on him. The Liaison called her and said Resident C was not allowed back into the facility. The call was on speaker phone in the car and the resident's sister heard the Liaison say that Resident C would not get his belongings back if he did not sign the discharge paperwork. The resident's phone and iPad were on the table and as she was getting the rest of the resident's belongings, the Liaison moved them (iPad and phone) to the nurses' station. Resident C was not offered the opportunity to return to the facility since he had not been arrested. Review of a current policy, dated 2/3/25, titled Transfer/Discharge Notice provided by the Administrator on 6/3/25 at 8:47 a.m , indicated the following: 1. Facility Requirements: a. This facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless --- (continued on next page)

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