

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Muncie		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to thoroughly assess and intervene to promote the healing of pressure injuries for 1 of 3 residents reviewed for injuries (Resident C). Finding includes: Resident C's clinical record was reviewed on 9/30/25 at 9:39 a.m. Diagnoses included fracture of unspecified part of neck of right femur, chronic kidney disease, stage 3, severe protein-calorie malnutrition, and dementia. Orders included wound nurse practitioner (NP) to provide wound management assessment and treatment by provider as needed (9/9/25), heel protectors while in bed, as tolerated (9/9/25), pressure relieving/redistribution mattress (9/8/25), pressure redistribution cushion to wheelchair (9/8/25), quetiapine (antipsychotic) 100 mg daily, trazodone (antidepressant) 100 mg daily, and sertraline (antidepressant) 25 mg daily. An admission Minimum Data Set (MDS) assessment, dated 9/12/25, indicated the resident was severely cognitively impaired. She had an impairment to her functional range of motion to her lower extremity on one side. She required substantial/maximal staff assistance for eating, oral hygiene, and personal hygiene. She was dependent on staff assistance for toileting hygiene, upper and lower body dressing, showering and bathing, putting on/taking off footwear, bed mobility, and transfers. She was always incontinent of bowel and bladder. She had a stage 2 (partial-thickness skin loss involving epidermis/dermis) unhealed pressure injury upon admission to the facility. An initial care plan for skin (9/8/25) included the following interventions: turn and reposition for comfort with care, elevate heels, provide pressure relieving device in chair, use lift sheet to reposition in bed, ensure resident in clean and dry, ensure adequate hydration, observe nutritional intake, encourage resident to float heels while in bed, and inspect skin when repositioning, toileting, and assisting with activities of daily living (ADLs) - notify nurse of adverse findings. A care plan for risk for pressure injury related to decreased mobility was initiated on 9/9/25 with a goal that skin will be intact, free of redness, blisters, discoloration or open areas over bone prominences through the next review date. Interventions included apply lotion after showering/bathing (9/9/25), avoid prolonged skin to skin contact (9/9/25), provide pressure relieving device: pressure relieving mattress, chair cushion (9/9/25), treatment per physician order (9/9/25), and weekly skin review (9/9/25). A nursing progress note, dated 9/8/25 at 6:05 p.m., indicated the resident was admitted to the facility. The resident was confused and drowsy. She had a right femoral neck fracture. A surgical site had a nonremovable dressing with surrounding edema. She had redness to her coccyx area, a stage 2 pressure injury on her right elbow, and red/purple discoloration to both her heels. An admission observation detail report, dated 9/8/25 at 6:13 p.m., indicated the resident had skin impairment upon admission and was at a high risk for developing pressure injuries. A skin integrity event, dated 9/8/25 at 6:50 p.m., indicated the resident had a pressure injury to the right elbow with the length of 1.7 cm and a width of 1.2 cm. The DON/wound nurse was notified to enter the findings into the wound management system. Immediate interventions included elevate heels, provide pressure relieving device in chair, turn and reposition for comfort with care, ensure the resident is clean and dry, and avoid positioning the resident directly on skin breakdown. A dietary progress note, dated 9/17/25 at 4:47 p.m., indicated the resident had a stage 2 pressure injury on elbow and redness to coccyx mentioned on nursing notes. A wound NP progress note, dated 9/23/25 at 6:01 p.m., indicated the resident had a pressure injury to the right elbow, coccyx, right heel, and left heel. The pressure injuries had previous treatments of dry dressing. The right elbow and coccyx pressure injuries were staged as unstageable (full-thickness loss of skin and tissue where the depth is obscured by yellow stringy or black, brown dead tissue). The left and right heels were staged as deep tissue injuries (DTI) (non-blanchable, purple or maroon discoloration of skin). The note indicated to look at wound management in the electronic medical record for a full wound assessment and for treatment recommendations. The right elbow, coccyx, left heel, and right heel had new recommendations based on the assessment that was completed. Associated wound care treatments were to be referenced under the orders in the resident's electronic medical record. The resident demonstrated an overall decline in wounds consistent with terminal illness/end of life. The NP recommended the staff discuss hospice consult with the resident and/or family due to the current wound care impact on the quality of life. The recommendations were discussed with the DON. The wound management detail report indicated a stage 2 pressure injury to the right elbow was identified on 9/8/25 (report created 9/18/25). The length was 1.7 cm, width 1.2 cm, and depth 0.1 cm. The report lacked additional assessments and measurements for the right elbow. The report lacked documentation for the coccyx and the heels. A nursing progress note, dated 9/24/25 at 7:45 a.m. indicated the resident was sent to the hospital. A hospital provider progress note, dated</p>		