

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 10/24/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>A. Based on interview and record review, the facility failed to report to the Indiana Department of Health (IDOH) an unusual occurrence, related to potential neglect, when an unprescribed controlled medication was found in a dependent resident's system during a hospital stay for 1 of 3 residents reviewed for neglect. (Resident B) Findings include: Resident B's clinical record was reviewed on 10/22/25 at 11:09 a.m. Diagnoses included unspecified dementia, essential primary hypertension, unspecified asthma, unspecified convulsions, and heart failure. The medication allergy list included gabapentin.</p> <p>Physician's orders included levothyroxine (thyroid medication) 25 milligrams (mg) by mouth once every morning and primidone (seizure medication) 50 mg by mouth at bedtime.</p> <p>An 8/20/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. She required set-up assistance from staff for eating, oral hygiene, toileting hygiene, and rolling left to right. The resident did not take opioids.</p> <p>A hospital progress note, dated 9/25/25 at 9:51 a.m. indicated the resident arrived with altered mental status. The emergency medical services reported concern about the resident's low respiratory rate, hypoxia, low blood pressure when the resident was transported to the hospital from the facility. The family requested a urine drug screen due to concerns that the resident may have received her roommate's medications again at the facility.</p> <p>A hospital progress note, dated 9/25/25 at 12:17 p.m., indicated upon arrival the resident was very lethargic with respirations of 5, temperature 96.6 degrees, and oxygen saturation of 85% to 88%. There was a concern with a medication mix up per the extended care facility with the roommate's medications of gabapentin and morphine (narcotic pain medication). The resident's urine drug screen was positive for barbiturates and opiates. The resident did not take opiates. After collection of the urine drug screen, the resident received Narcan (life-saving medication to reverse the effects of an opioid overdose). The resident was admitted to the hospital for altered mental status.</p> <p>During an interview on 10/24/25 at 4:03 p.m., the DON indicated the facility would have reported Resident B's unusual occurrence on 9/25/25 to the Indiana Department of Health if the night shift nurse said she made a medication error. It was not reported because the facility did not find an error. The facility followed the IDOH guidelines for reporting potential alleged neglect.</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
-----------------------------------------------------------------------	-------	-----------

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 10/24/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, last reviewed 1/31/25, titled Abuse, Neglect and Misappropriation of Property, provided by the Administrator on 10/22/25 at 11:30 a.m., indicated the following: POLICY STATEMENT. It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. The Facility Administrator is responsible for reporting all investigations' results to applicable State agencies as required by Federal and State law. Immediately. All alleged violations involving abuse, Neglect, exploitation, or mistreatment are reported immediately, but no later than two hours after the allegation is made. In other words, all allegations and incidents of abuse or neglect, as defined in this policy, will be reported immediately, as defined in this paragraph.</p> <p>Cross reference F610</p> <p>This citation relates to Intakes 2634309 and 2641871.</p> <p>3.1-28(c)</p>		

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 10/24/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to complete a thorough investigation of an unusual occurrence related to potential neglect when an unprescribed substance was found in a resident during a hospital stay for 1 of 3 residents reviewed for neglect. (Resident B) Findings include: Resident B's clinical record was reviewed on 10/22/25 at 11:09 a.m. Diagnoses included unspecified dementia, essential primary hypertension, unspecified asthma, unspecified convulsions, and heart failure. The medication allergy list included gabapentin (seizure medication).</p> <p>Physician's orders included levothyroxine (thyroid medication) 25 milligrams (mg) by mouth once every morning and primidone (seizure medication) 50 mg by mouth at bedtime.</p> <p>An 8/20/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. She required set-up assistance from staff for eating, oral hygiene, toileting hygiene, and rolling left to right. The resident did not take opioids.</p> <p>A care plan, revised 8/26/25, indicated the resident had an allergy to gabapentin. Interventions included do not give anything on the allergy list to the resident (3/15/20).</p> <p>A progress note, dated 8/25/25 at 11:00 a.m., indicated the provider and the resident representative were notified regarding an (in error) administration of gabapentin (neuropathy) 300 milligram (mg) and clopidogrel (anti-platelet) 75 mg by mouth.</p> <p>An event note, dated 8/25/25 at 12:29 p.m., indicated Resident B was given her roommate's medication in error due to responding to the wrong name twice.</p> <p>A progress note, dated 8/25/25 at 3:28 p.m., indicated Resident B had dementia and at baseline could not identify who she was.</p> <p>A hospital progress note, dated 8/25/25 at 3:45 p.m., indicated Resident B was administered her roommate's medications at the skilled nursing facility.</p> <p>Review of a progress note, dated 9/25/25 at 8:12 a.m. indicated the CNA informed a nurse that the resident was off. Vitals were obtained with temperature 97.7 degrees, pulse 66, respirations 16, oxygen saturation 93% on room air, and blood pressure 85/42. The CNA informed the nurse that the resident had stated that she felt like her next breath was going to be her last one. The resident was encouraged to drink her fluids and eat some breakfast. The resident took sips and shook her head no to eating and drinking more. The resident was assisted to her room where she was assisted in bed with her head down and feet up to assist with low blood pressure. The provider was notified and new orders were received for labs. The provider planned to see the resident that day.</p> <p>A progress note, dated 9/25/25 at 8:15 a.m., indicated an assessment was completed and the resident was observed to be increasingly lethargic. The resident indicated she had never felt that way before. Family wanted the resident to be sent to the ER upon their arrival at the facility.</p> <p>A progress note, dated 9/25/25 at 9:00 a.m., indicated the family arrived and emergency medical services were contacted to transport the resident to the emergency room for evaluation.</p> <p>(continued on next page)</p>		

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 10/24/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 9/25/25 at 9:15 a.m., indicated the resident exited the building via stretcher with emergency medical services and family.</p> <p>A hospital progress note, dated 9/25/25 at 9:51 a.m. indicated the resident arrived with altered mental status. The emergency medical services reported concern about the resident's low respiratory rate, hypoxia, low blood pressure when the resident was transported to the hospital from the facility. The family requested a urine drug screen due to concerns that the resident may have received her roommate's medications again at the facility.</p> <p>A hospital progress note, dated 9/25/25 at 12:17 p.m., indicated upon arrival the resident was very lethargic with respirations of 5, temperature 96.6 degrees, and oxygen saturation of 85% to 88%. The resident got up and went to breakfast at the extended care facility and indicated she did not feel well. The resident told staff she thought she was going to take her last breath. Staff noted she was lethargic. Family were at the bedside and noted they saw the resident yesterday and she was in her normal state of health. The resident's pupils were small and the resident had no verbal communication. She had a low heart rate with trace lower extremity swelling. There was a concern with a medication mix up per the extended care facility with the roommate's medications of gabapentin and morphine (narcotic pain medication). The resident's urine drug screen was positive for barbiturates (controlled medications) and opiates. The resident did not take opiates. After collection of the urine drug screen, the resident received Narcan (life-saving medication to reverse the effects of an opioid overdose). The resident was admitted to the hospital for altered mental status.</p> <p>During entrance conference on 10/22/25 at 10:20 a.m., the Administrator and DON provided recent facility investigations, which lacked an investigation for Resident B for 9/25/25.</p> <p>During an interview on 10/23/25 at 9:27 a.m., the DON indicated Resident B had one prior medication error and it occurred on 8/25/25. She had to review the record to see if an investigation was conducted regarding a potential medication error on 9/25/25.</p> <p>Review of the facility investigation for the unusual occurrence on 9/25/25, included the following information:</p> <p>Seventy-one resident questionnaires contained two questions that could be answered yes/no, but the resident's roommate (potential witness) was not included. None of the questionnaires were dated, timed, nor indicated who completed the questionnaires with the residents.</p> <p>Thirty-one skin assessments were completed on 9/25/25 with no skin issues identified.</p> <p>The investigation lacked any statements from pertinent staff who were on duty or may have cared for Resident B when/surrounding the date and time when the unusual occurrence happened.</p> <p>No statements were included from emergency medical services staff who transported Resident B from the facility to the hospital on 9/25/25.</p> <p>No resident or representative statements from those who were at the facility the morning Resident B was sent out to the hospital were included in the facility investigation.</p> <p>(continued on next page)</p>		

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 10/24/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident C's clinical record was reviewed on 10/23/25 at 12:30 p.m. Diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side, fibromyalgia, unspecified epilepsy, other chronic pain, and expressive language disorder.</p> <p>Physician's orders included clopidogrel (anti-platelet) 75 mg by mouth once daily, gabapentin 300 mg by mouth three times a day, levetiracetam (seizure) 500 mg by mouth two times a day, and morphine 60 mg extended-release tablet by mouth two times a day.</p> <p>The MAR indicated Resident C received gabapentin 300mg cap, levetiracetam 500 mg tab, and morphine 60 mg extended-release tablet on 9/25/25 at 6:05 a.m.</p> <p>A 9/8/25, annual, MDS assessment indicated Resident C was severely cognitively impaired. Resident C required partial assistance from staff for toileting hygiene, upper body dressing, bathing, rolling left and right, toilet transfers, and chair to bed transfers. She required substantial assistance from staff for lower body dressing. A manual wheelchair was used for mobility. The resident was taking opioids.</p> <p>A current care plan, revised 9/21/25, indicated Resident C had impaired communication related to expressive aphasia. She is able to answer yes/no questions, nod head yes/no, uses hand gestures, uses communication board, and is able to say some words. Interventions included the following: use communication techniques to facilitate interaction; use preferred name; identify yourself with each contact; and face the resident when speaking and make eye contact (8/15/19), have the resident to use her communication board in her electronic device (12/9/20), and observe for non-verbal cues (3/2/23).</p> <p>During an interview, on 10/22/25 at 7:32 p.m., LPN 3 indicated on 9/24/25 at 11:00 p.m., she took over the 100 Unit and worked until 7:00 a.m. on 9/25/25. LPN 3 was not familiar with the residents nor the staff. When unfamiliar with the residents, LPN 3 asked the residents their name and date of birth prior to medication administration to ensure the correct medications were administered to the correct resident. No residents were unable to state their name and date of birth on the 100 Unit on her shift from 9/24/25 &ndash; 9/25/25. No one assisted LPN 3 with the medication administration on the shift and there were no problems getting the medications passed. There were a few refusals that were documented and some narcotics LPN 3 administered on the 100 Unit during that shift. LPN 3 did not ask other staff to assist with identifying the residents. Mid-morning on 9/25/25, the DON contacted LPN 3 at home and told LPN 3 the resident in question had become unresponsive, sent to the hospital and tested positive for an unprescribed narcotic. The DON led LPN 3 to believe the resident had been administered the narcotic erroneously.</p> <p>During an interview on 10/23/25 at 1:07 p.m., Resident C was seated in her wheelchair in her room, unable to verbalize her name and date of birth , but she was able to point to her name on her tablet and confirmed yes when her birthdate was stated. She remembered the date Resident B declined and was sent out of the facility. Resident B had not returned to the facility since that time. Resident C indicated she normally received medications early in the morning. On the day Resident B was sent out, Resident C seen a nurse come into their room that morning. The nurse came into their room early in the morning and administered medication to Resident B, but she did not administer any early medications to Resident C that morning. Resident C indicated Resident B typically walked around the room with her walker and ate breakfast and lunch in the dining room. Resident C was concerned and had reported that morning to a management staff member about her concern that Resident C had not received her medications early that morning and Resident B had received medication.</p> <p>(continued on next page)</p>		

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 10/24/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Confidential interviews were conducted during the course of the survey and indicated the following:</p> <p>Resident B was typically known to walk with her walker to the dining room with standby assistance each morning for breakfast. Resident B was not known to become lethargic on days shift after taking her medications.</p> <p>Resident B was unable to state her date of birth due to cognitive impairment. Resident B was not familiar with what medications she took and when handed a cup of pills would just tip the cup up and take whatever was in the medication cup without question. Resident C had aphagia with difficulty conveying her message but understood and could answer questions appropriately. It was better to ask questions that could be answered with yes and no for Resident C. Resident C knew her medications and always checked her medications to ensure they were correct before she took them. Due to the aphasia, Resident C was unable to state her name and date of birth. Resident C was not known to report she had not received her medications once she had received them for the day. Both Residents B and C took their medications whole.</p> <p>On 9/25/25, Resident B was her normal self around 6:00 a.m. that morning. Around approximately 7:15 a.m., upon assisting Resident B out of her room and towards the dining room with her walker, she seemed a little out of breath, more confused, and began shuffling her feet when the resident was just a few steps out of her room. As a result, the resident was assisted to the dining room for breakfast in the wheelchair. While on the way to the dining room, LPN 3 was giving report to LPN 4 at the nurses' station. Upon passing the nurses' station, LPN 3 was asked if Resident B had any concerns throughout the night shift. LPN 3 responded that everything had been normal. While in the dining room, Resident B told CNA 5 and CNA 6 she thought her next breath may be her last. They immediately stopped RN 7 and asked for her to evaluate Resident B because the resident did not seem to be herself. RN 7 immediately took over.</p> <p>(continued on next page)</p>

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 10/24/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The morning of 9/25/25, Resident B was a little more sleepy than usual when she got dressed. Once the resident was in the dining room in the wheelchair, Resident B was more confused and lethargic. The resident made the statement she thought her next breath was going to be her last breath. This information was immediately shared with RN 7 who assessed the resident. LPN 3 was also stopped just prior to leaving the facility to be asked if Resident B had been ill through the night. LPN 3 denied any concerns. Once RN 7 assessed the resident, they communicated with LPN 4 who was assigned to the 100 Unit, then another staff member assisted Resident B back to her room. The resident had not eaten or drank for breakfast. Typically, the resident ate fairly well for breakfast. Resident B had visitors, who notified staff that Resident B wasn't breathing right and her color was off. RN 7 was immediately notified and LPN 4 also came to the room. Nursing put oxygen on the resident. The resident was transferred to the hospital. Once Resident B was sent out to the hospital, it was recognized that Resident C was crying, initially thought to be out of concern. Resident C understood but had difficulty verbalizing. As a result, it took some time to console and communicate with Resident C. After several questions, Resident C communicated she had not received her medications early that morning, Resident B had received medications early that morning, and Resident C was worried because she believed Resident B had been given her medications in error early that morning. LPN 4 on the 100 Unit was immediately notified. The DON was not in her office so the ADON was immediately notified and requested to go directly to Resident C's room to inquire with more questions. When the ADON went in Resident C's room the ADON confirmed with Resident C that Resident B was believed to have received Resident C's medications early that morning. The ADON left the resident room and was then seen talking with the DON. The status of the reported concern was unknown.</p> <p>During an interview on 10/23/25 at 1:42 p.m., the ADON indicated she was at the facility on 9/25/25 when Resident B was sent out for a change of condition. She could not remember if anyone brought any information to her attention regarding Resident B and Resident C and their medications. She could not remember if she had spoken to Resident C, and she could not recall if she went to Resident B and Resident C's room that day.</p> <p>On 10/24/25 at 4:03 p.m., the DON indicated she was aware of the previous medication error that occurred on 8/25/25, when Resident B received Resident C's medications, as the DON had assisted in the facility's investigation. She was notified on 9/25/25 around 9:00 a.m. that Resident B did not eat well, and they were going to send the resident out for shortness of breath. The DON and Administrator had completed the facility investigation for 9/25/25. The hospital Case Manager contacted the DON on 9/25/25, asked about the medication list, and notified her the resident tested positive for opiates on the drug screen. Resident B did not have orders for opiates and the DON was aware. She did not communicate with the hospital that Resident B had previously received Resident C's medication on 8/25/25. Resident C could have answered yes/no questions, but she could not state her name and date of birth. Resident C's cognition was impaired, so a statement was not taken from her. They did not have staff statements because they did not find anything on their end.</p> <p>On 10/24/25 at 4:54 p.m., the Administrator indicated she had not collected any statements because the DON talked to the nursing staff. The facility could not confirm who had been spoken with since no statements were collected. No further information was provided.</p> <p>(continued on next page)</p>		

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 10/24/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The article, Morphine, dated 3/27/25, was retrieved on 11/14/25 at 10:03 a.m. from the National Institute of Health (NIH) website https://www.ncbi.nlm.nih.gov/books/NBK526115/#article-25271.s8. The guidance included : According to the Centers for Disease Control Prevention (CDC) guidelines, clinicians should not use extended-release/long-acting opioids, including morphine, to treat acute pain or initiate opioid treatment for subacute or chronic pain. Due to their longer half life and duration of effects, such as respiratory depression, ER/LA opioids should be reserved for severe continuous pain. Toxicity. Signs and Symptoms of Overdose. Morphine can potentially be a lethal medication when not used properly. This medication causes a host of symptoms related to CNS depression. Severe respiratory depression is the most feared complication of morphine in cases of overdose. Acute morphine overdose can be present with a variety of symptoms, including respiratory depression, skeletal muscle flaccidity, cold and clammy skin, hypoglycemia, bradycardia, hypotension, constricted pupils, pulmonary edema, somnolence progressing to coma, partial or complete airway obstruction.</p> <p>The article, Extended-release morphine sulfate in treatment of severe acute and chronic pain, dated 9/21/10, was retrieved on 11/17/25 from the NIH website at https://pmc.ncbi.nlm.nih.gov/articles/PMC3004644/. The guidance included: Pharmacodynamics. It takes approximately 30 minutes for the immediate-release morphine formulation to reach the central nervous system, and 90 minutes for the extended-release formulation.</p> <p>A current facility policy, last reviewed 1/31/25, titled Abuse, Neglect and Misappropriation of Property, provided by the Administrator on 10/22/25 at 11:30 a.m., indicated the following: POLICY STATEMENT. It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin. and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated. The organization's policy is that the Facility Administrator, or his or her designee, will conduct a reasonable investigation of each such alleged violation.</p> <p>This citation relates to Intakes 2634309 and 2641871.</p> <p>3.1-28(d)</p>		