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	11/18/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to complete neurological assessments as indicated by facility protocol following falls for 1 of 3 residents reviewed for accidents. (Resident C)Finding includes:Resident C's clinical record was reviewed on 11/17/25 at 2:42 p.m. Diagnoses included vascular dementia, cerebral infarction, essential primary hypertension, repeated falls, unspecified fracture of facial bones, unsteadiness on feet, and generalized muscle weakness. Current orders included tramadol (narcotic for pain) 25 mg three times daily as needed for pain, metoprolol succinate (blood pressure) 25 mg 0.5 tablet once daily, and aspirin (blood thinner for coronary artery disease) 81 mg once daily. A physician order for clopidogrel (blood thinner for coronary artery disease) 75 mg once daily was ordered on 7/15/25 and discontinued on 11/14/25. Review of the Medication Administration Records for August, September, October and November 2025 indicated the resident was taking both aspirin and clopidogrel during those months. Clopidogrel was discontinued by hospice on 11/14/25. An 11/4/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired. Resident C required partial assistance from staff for toileting hygiene, toileting transfers, chair/bed-to-chair transfers, and bathing. He required supervision for lower body dressing, donning and doffing footwear, and for walking 10 feet. The resident used a wheelchair for mobility. He had one fall with injury and 1 fall with major injury since the prior assessment. Resident C's current care plans included the following:A 7/16/25 problem of risk for fall related to a history of falls. Interventions included encourage/assist resident to assume a standing position slowly (7/16/25), provide nonskid footwear (7/16/25), provide visual cues for resident to ask for assistance prior to transfers (8/18/25), staff to assist the resident back to bed right after meals (9/29/25), keep frequent used items in reach (9/30/25), walk to dine as tolerated (10/14/25), and silent bed alarm as tolerated (11/4/25). A 7/17/25 problem of risk for bleeding/bruising related to medication. Interventions included the following: Observe for signs and symptoms of bleeding such as nose bleeds, Report abnormal finding to the physician/nurse practitioner (7/16/25)., and report to the physician any abnormal bleeding (7/16/25). An 11/6/25 problem of multiple fractures of the face secondary to a fall. Interventions included report emergence of hematoma or hemorrhage (11/6/25). Review of Resident C's unwitnessed fall events in the clinical record included the following:Fall with no injury in the resident's room on 8/17/25 at 1:37 a.m. Fall with no injury in the resident's room on 9/25/25 at 8:00 a.m. Neurological assessments #12, #13, and #14 were blank. Fall in the resident's room with bleeding laceration to the right eyebrow on 9/30/25 at 4:30 p.m. Neurological assessments #10, #11, #12, #13, and #14 were blank. Fall with no injury in the resident's room on 10/13/25 at 10:00 a.m. Fall with multiple facial fractures in the resident's room on 11/4/25 at 2:25 a.m. A progress note, dated 11/4/25 at 8:50 a.m., indicated the Administrator and the Nurse Practitioner evaluated the resident this morning. The resident's forehead and nose were still bleeding at this time. Bruising was noted on the resident's left eye. An order was received to send the resident to the emergency room for evaluation. A CT Maxillofacial without IV Contrast, dated 11/4/25, indicated the following impression: Acute nasal bone fractures are comminuted and mildly displaced to the right with some depression of the fracture fragments on the left. Acute fractures are also evident along the right greater than left maxillary frontal processes and nasal (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 - Minimal harm or potential for actual harm Residents Affected - Few	septum, which is displaced and buckled. Scalp and nasal dorsum soft tissue injury extends inferiorly to involve the walls of the nasal vestibule with thickening along the cartilaginous nasal septum and asymmetric left nasal valve stenosis. An osseous defect along the anterior wall of the right external auditory canal is suspicious for an acute tympanic plate fracture. During an observation on 11/18/25 at 12:18 p.m., Resident C was seated in his wheelchair in the dining room with non-skid socks noted on his feet. The resident had dark purple discoloration on his bilateral lower periorbital portion of his face. On 11/18/25 at 2:20 p.m., the DON indicated, during review of neurological assessments for Resident C's unwitnessed falls on 9/25/25 and 9/30/25, the neurological assessments should have been completed with unwitnessed falls and falls when the resident hit their head. There were blank neurological assessments for Resident C's 9/25/25 and 9/30/25 unwitnessed falls. The DON indicated the facility lacked a policy regarding fall prevention, unwitnessed falls, and neurological assessments. During an interview on 11/18/25 at 3:05 p.m., LPN 4 indicated unwitnessed falls and falls when a resident hit their head required immediate neurological assessment initiation. She indicated the neurological assessments were completed on the fall event note and the facility also provided a paper neurological assessment sheet for them to utilize and reference a couple of weeks ago. A request was made for a copy of the paper format titled Neuro Check Times Guidance Chart. LPN 4 indicated she would ask the DON for a copy for review. On 11/18/25 at 3:23 p.m., LPN 5 indicated unwitnessed falls and falls when a resident hit their head required immediate neurological assessment initiation and ongoing neurological assessments that were to be completed entirely over multiple shifts. She indicated she also had a paper copy to reference for the neurological assessments. LPN 5 indicated she would ask the DON for a copy for review. On 11/18/25 at 3:44 p.m., RN 6 indicated it was not acceptable to leave the neurological assessments incomplete or blank because one would not be able to identify a change in the resident's neurological status without them. Neurological assessments should be initiated immediately and completed every 15 minutes x4, then every 30 minutes x 4, then every hour x 4, then every 4 hours x 4. On 11/18/25 at 4:03 p.m., the Administrator indicated the facility would not provide a copy of the Neuro Check Times Guidance Chart for review because it was not the facility's policy or procedure. She indicated neurological assessments were required to be completed with unwitnessed falls and falls when residents hit their head. On 11/18/25 at 4:19 p.m., LPN 7 indicated she was on duty when Resident C had an unwitnessed fall in his room on 11/4/25. She heard a noise and ran to the resident's room where she found the resident on the floor lying on his right side with his plastic coffee mug still in his hands. Resident C's nose was bleeding, and he was trying to wipe the blood away with the coffee mug in his hands. Resident C explained he hit his nose on the floor. He was close to the entrance door of his room near his roommate's bed, laughing, and talking to his roommate while lying in the floor. His wheelchair was still back by his bed as though he had forgotten it. He denied pain. She stopped his nose bleed and assessed the resident to include neurological assessments. He was assisted into the restroom, cleaned him up from the bleeding, and then assisted back to bed. She called the on-call provider services line that could be utilized for non-emergent situations and was unable to speak with anyone. She felt it was not an emergency since the resident was not exhibiting pain and was laughing. She left a message about the fall on the provider service line. On 11/18/25 at 4:39 p.m., RN 8 indicated nursing staff followed the fall event note so they would know what had to be completed when they had an unwitnessed fall. This citation relates to Intakes 2660002 and 2662023. 3.1-37(a)