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	03/20/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure dishware and utensils were washed in a method to ensure proper sanitization. This deficient practice had the potential to impact 111 of 111 residents who consumed food prepared in the facility's kitchen. Findings include: During an observation of dishwasher testing, on 3/16/26 at 10:35 a.m., the Dietary Manager tested the dishwasher on three separate occasions. Each attempt registered no sanitizing solution in the final rinse water. The Dietary Manager obtained a second container of sanitation test strips and ran the dishwasher cycle again, which resulted in an indication of no sanitizing solution in the final rinse. The facility testing log, posted on the wall in the dish room, indicated the sanitizer that morning had indicated 100 parts per million (ppm). The signature of the person who completed the test was illegible. When interviewed, no employee present in the dietary department indicated they made the log entry. The two employees working in the dish room when the Dietary Manager completed the testing indicated they had not made the entry. The Dietary Manager did not know who had made the entry regarding sanitizer solution level.A copy of a facility poster located in the dishwasher room, provided by the Corporate Nurse Consultant via email on 3/18/26 at 1:37 p.m., indicated:Sanitizing Dish Machinewash temperature range: 120 to 140rinse temperature range 120 to 140chemical sanitizing PPM (parts per million) range between 50 and 100 During an interview on 3/16/26 at 3:10 p.m., the Dietary Manager indicated she believed there had been a problem with the proper testing and documentation of dishwasher sanitation for about one month. During an interview on 3/30/26 at 9:00 a.m., the Corporate Nurse Consultant indicated only one of the facility's residents did not consume food orally. All other 111 residents ate meals prepared in the facility's kitchen. A facility document, dated March 16, 2026 at 2:26 p.m., titled [dishwasher maintenance company's name] report, and provided via email by the Interim Administrator in 3/16/26 at 2:42 p.m., indicated the following:Parts replaced: squeeze tube, - sanitizer inspecting and updating to optimize and protect equipment operation .Machine condition: issue found inspecting machine health for optimal water and energy consumption.,Comments: here was some clogging on the bottom nozzle. replaced arm. A current facility document titled Education on using a low temp dishwasher, provided by the Corporate Nurse Consultant on 3/18/26 at 1:37 p.m. indicated the following: .All dishware, serviceware, and utensils will be cleaned and sanitized after each use. All dining service staff will be knowledgeable in the proper techniques for processing dirty dishware. Through the dish machine and proper handling of sanitized dishware, all dish machine water temperatures will be maintained in accordance with manufacturer's recommendation for low temperature or high temperature machines. Temperature and/or sanitizer concentration logs will be completed as appropriate. All dishware will be air dried and properly stored Check sanitizer concentration, use the chemical test strips regularly to confirm the chlorine concentration is sufficient (100 to 200 parts per million).to test the concentration run a rack through the cycle, while the rack is running at the end of the machine where the rack will come out, stick a test strip inside the machine towards the top, where the sprayers are spraying. You will see the strip turn color, remove the strip and compare it to the color chart on the bottle of test strips. Record the concentration on the log. 410 IAC (Indiana Administrative Code) 16.2-3.1 -21(i)(3)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on observation, interview, and record review, the facility failed to protect residents' rights to be free from involuntary seclusion related to placement in a secured unit without meeting criteria when the facility failed to ensure a locked dementia unit was approved by the Indiana Department of Health prior to the unit being locked and failed to ensure residents who resided on the unit required a locked unit to treat a medical/behavioral condition for 5 of 5 residents reviewed of 18 who resided on the secured unit. (Residents 6, 87, 94, 12, and 3).Findings include:During the entrance conference, on 3/16/26 at 9:48 a.m., the Interim Administrator indicated the facility had a secure dementia unit.An Alzheimer's/Dementia Special Care Unit, State Form 48896, dated 3/17/26 and provided via email by the Corporate Nurse Consultant on 3/18/26 at 12:50 p.m., indicated the following:The facility did not have a mission or philosophy statement concerning the needs of residents with Alzheimer's disease, a related disorders or dementia.The criteria for admission, transfer, and discharge included: a physician's evaluation/diagnosis, staff evaluations, psychiatric evaluation/diagnosis, and a family conference.The Alzheimer's dementia care program was located in a separate, locked unit. During an interview on 3/18/26 at 12:50 p.m., the Corporate Nurse Consultant indicated the corporation was unable to provide a dementia disclosure form completed prior to 3/17/26.During an interview on 3/19/26 at 9:42 a.m., the Regional Clinical Support, [NAME] President of Clinical Operations, and [NAME] President of Operations all indicated they could not locate record of a Certificate for Occupancy being issued by IDOH (Indiana Department of Health) and would contact their home office to begin working toward getting the proper authorization for securing the dementia unit.During an interview on 3/20/2026 at 11:16 a.m., LPN 23 and LPN 4, who were identified by the facility as being a part of the team to secure the dementia unit, indicated the facility had chosen to lock the dementia unit in response to an identified need for secured dementia care in the Delaware County community. During an interview on 3/20/2026 at 12:55 p.m., QMA 19 indicated she had worked on the dementia unit in December 2025, before the facility locked the unit. She was unaware of any concerns regarding residents' unsafe wandering prior to the doors being locked. No residents who currently resided on the unit displayed exit seeking behaviors. One resident did pace, but was not exit seeking.During an interview on 3/20/2026 at 12:58 p.m., LPN 20 indicated she was knowledgeable of the residents who resided on the secured dementia unit. Prior to the doors being locked in January 2026, there was a resident who walked and paced but they did not attempt to exit the unit. Since the unit doors were locked in January 2026, she had not noticed residents displaying exit seeking behaviors. She did not know why the decision was made to lock the dementia unit.During an interview on 3/20/2026 at 1:01 p.m., LPN 21 indicated she had worked on the dementia unit prior to the doors being locked in January 2026. She had not witnessed any residents exit seeking before the doors were locked. She had not witnessed any residents exit seeking after the doors were locked.During an interview on 3/20/2026 at 1:03 p.m., C.N.A. 22 indicated the residents on the dementia unit sometimes paced, but they did not exit-seek. 1 Resident 6's clinical record was reviewed on 3/17/26 at 3:11 p.m. Current diagnoses included major depressive disorder, generalized anxiety disorder, diabetes mellitus, and vascular dementia. The resident had lived in their current room prior to the unit being locked in January of 2026.The resident had a 1/27/26 at 4:20 p.m., Social Service Note, which indicated the resident's representative had been contacted and informed the resident's hall was being transitioned to a locked unit.The resident had a 1/28/26 physician's order to admit to gated community due to vascular dementia. Special Instructions: include reason for admission to gated community.A 1/28/26 Secured Unit Observation document indicated the observation was unscheduled and being completed due to the initiation of a gated community. The form indicated an IDT (Interdisciplinary Team) team meeting, consisting of at least a nurse, social services, MD/NP (medical doctor or nurse practitioner), had met to evaluate for placement for a secured unit. A care plan was developed at this time. The resident (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not identified as a risk for elopement.An 8/27/25 care plan indicated the resident had cognitive loss due to dementia. An approach to this problem was to provide a home-like therapeutic environment.The resident had a 12/3/25, MDS (Minimum Data Set) assessment , completed prior to her residing on a secured unit, which indicated the resident was severely cognitively impaired, had moderate depression, and displayed no maladaptive behaviors during the assessment, including wandering.A 1/30/26 care plan problem/need indicated the resident was placed in a locked unit as a least restrictive approach to protecting the resident and assuring his or her health and safety.The resident did not have a care plan problem/need related to risk for elopement or exit seeking behaviors.The resident had a 3/5/26 MDS assessment, completed after she resided on a secured unit, indicated the resident was severely cognitively impaired and displayed no maladaptive behaviors during the assessment, including wandering.Prior to the resident order to reside on a dementia unit, the resident had no documentation of exit seeking behaviors from 10/1/25 to 1/28/26.Prior to the 1/27/26 order for the resident to reside on a dementia unit, the clinical record lacked: a. An assessment of the resident's need for a secure dementia unit,b. Documentation regarding a care conference held in conjunction with the resident's representative to address the need for a secured dementia unit,c. An assessment or evaluation completed by the resident's physician, which determined the resident's need for a secured dementia care unit,d. An IDT note which addressed the resident's need for a secured dementia unit.e. Documented incidents of wandering for the period of time from 12/1/25 to 3/16/26.The clinical record indicated the resident's room was not relocated on 1/28/26. The change in the resident's services on 1/28/26 was the unit was locked on that date. During an observation on 3/16/ 26 at 12:36 p.m., Resident 6 was in the activity and dining area of the dementia unit.During an observation on 3/19/26 at 12:12 p.m., the resident exited the dining room and took herself to her bathroom. 2. Resident 87's clinical record was reviewed on 3/17/26 at 3:15 p.m. Current diagnoses included Alzheimer's disease, anxiety, mood disturbance, and unspecified dementia. The record indicated the resident resided in the same room they lived in prior to the unit being locked. A 1/27/26, 4:03 p.m. Social Service Note indicated the resident's guardian had been notified of the plan to transition the residents' hall to a locked unit. The resident had a 1/28/26 order to admit to gated community due to Alzheimer's. Special instructions include reason for admission to gated community.A 1/28/26 observation form for a Gated Community Assessment indicated the assessment was unscheduled and had been completed due to consent for gated community and a care plan had been developedThe resident had a 1/26/26 care plan problem/ need regarding placement in a locked unit as the least restrictive approach to protect the resident and assure his/ her health and safety.The resident had a 2/17/26 care plan problem/ need regarding the risk for elopement due to seeking behaviors. The resident's clinical record from 10/1/25 to 2/1/26 lacked documentation of any elopement attempts during this period of time.The resident had an 11/12/20 care plan problem/ need regarding a potential for decline in mood related to a diagnosis of dementia.Prior to the 1/27/26 order for the resident to reside on a dementia unit, the clinical record lacked: a. An assessment of the resident's need for a secure dementia unit,b. Documentation regarding a care conference held in conjunction with the resident's representative to address the need for a secured dementia unit,c. An assessment or evaluation completed by the resident's physician, which determined the resident's need for a secured dementia care unit,d. An IDT note which addressed the resident's need for a secured dementia unit.e. Documented incidents of wandering for the period of time from 12/1/25 to 3/16/26.The clinical record indicated the resident's room was not relocated on 1/28/26. The change in the resident's services on 1/28/26 was the unit was locked on that date. During an observation 3/17/26 at 10:31a.m., Resident 87 was in bed, her eyes were closed, her mouth was open.During an observation on 3/19/26 at 11:19 a.m., the resident was in her room visiting with a guest.During an observation on 3/19/26 at 12:09 p.m., the resident was eating lunch in the dementia unit dining room. 3. Resident 94's clinical record was reviewed on 3/17/26 at 3:19 p.m. Current diagnoses included vascular dementia, peripheral vascular disease, and hypertension. The (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had a physician's order, dated 1/26/26, to admit to grated community due to vascular dementia, mild with agitation special instructions include reason for admission to gated community. A 1/27/26 at 4:28 p.m., Social Service Note indicated the resident's guardian had been notified of a plan to transposition the residents hall to a locked unit. The record indicated the resident had not relocated his room of residence following this order.The resident had a 1/29/26 Observation for Secure Unit form, which indicated the observation was unscheduled and was completed due to initiation to gated community.The resident had a 1/26/26 care plan problem/ need regarding resident placed in locked unit as least restrictive approach to protect the resident and assure his/her health and safety.The resident had a 2/26/26 care plan problem/ need regarding risk for social isolation due to syncope and collapse.The resident had a 2/17/26 care plan problem need regarding a risk for elopement due to exit seeking behaviors. The resident's clinical record lack documentation of elopement attempts during this time period.A 2/21/26, quarterly, MDS assessment indicated the resident was severely cognitively impaired, had minimum depression and had displayed no maladaptive behaviors during the assessment period including wandering.Prior to the 1/27/26 order for the resident to reside on a dementia unit, the clinical record lacked: a. An assessment of the resident's need for a secure dementia unit,b. Documentation regarding a care conference held in conjunction with the resident's representative to address the need for a secured dementia unit,c. An assessment or evaluation completed by the resident's physician, which determined the resident's need for a secured dementia care unit,d. An IDT note which addressed the resident's need for a secured dementia unit.e. Documented incidents of wandering for the period of time from 12/1/25 to 3/16/26.The clinical record indicated the resident's room was not relocated on 1/28/26. The change in the resident's services on 1/28/26 was the unit was locked on that date. During an observation on 3/17/26 at 10:33 a.m., Resident 94 was resting on the bed in his room.During an observation on 31926 at 11:18 a.m., the resident was resting on the bed in his room.During an observation on 3/19/26 at 12:10 p.m., the resident was in the dining room on the secure dementia unit. 4. Resident 12's clinical record was reviewed on 3/17/26 at 3:31p.m. Current diagnoses include Alzheimer's disease, major depressive disorder, and autistic disorder.The resident had a 1/6/26 significant MDS assessment which indicated the resident, was severely cognitively impaired and had displayed no maladaptive behaviors during the assessment period including wandering.The resident had a 1/27/26, 4:12 p.m., Social Service Note, which indicated the resident's representative, had been notified of a plan to transition the residence hall to a locked unit.The resident had a 1/28/26 physician's order to admit to gated community due to dementia. Special instructions include reason for admission to gated community.A 1/28/26, Observation for Secured Unit form indicated the observation was unscheduled and had been completed due to the initiation of gated community.The resident had a 1/30/26 care plan problem/ need to place in a locked unit as least restrictive approach to protect the resident and assure his/her health and safety.The resident had a 1/29/26, quarterly, MDS assessment which indicated the resident was severely cognitively impaired and had displayed no maladaptive behaviors during the assessment period, including wandering.Prior to the 1/27/26 order for the resident to reside on a dementia unit, the clinical record lacked: a. An assessment of the resident's need for a secure dementia unit,b. Documentation regarding a care conference held in conjunction with the resident's representative to address the need for a secured dementia unit,c. An assessment or evaluation completed by the resident's physician, which determined the resident's need for a secured dementia care unit,d. An IDT note which addressed the resident's need for a secured dementia unit.e. Documented incidents of wandering for the period of time from 12/1/25 to 3/16/26.The clinical record indicated the resident's room was not relocated on 1/28/26. The change in the resident's services on 1/28/26 was the unit was locked on that date.During an observation on 3/16/26 at 12:49 p.m., Resident 12 propelled his wheelchair out of the dementia unit dining room.During an observation on 3/17/26 at 10:32 a.m., Resident 12 was resting on the bed in his room.During an observation on 3/19/26 at 11:18 a.m., the resident was resting on the bed in his room.During an observation on (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/19/26 at 12:10 p.m., the resident was seated at a table in the dining room on the dementia care unit.5. Resident 3's clinical record had been reviewed on 3/17/26 at 3:35 p.m. Current diagnoses included neurocognitive disorder with Lewy bodies, cognitive communication deficit, and visual hallucinations.The resident had a 1/30/26 physician's order to admit to gated community due to neurocognitive disorder with Lewy bodies. Special instructions include reason for admission to gated community.The resident had a 1/27/26 4:39 p.m., Social Service Note, which indicated the resident's representative, was notified of the plan to transition the residence hall to a locked unit.A 1/30/26 Secure Unit Observation form indicated the observation was unscheduled and was completed due to initiation of gated community.The resident had a 1/30/26 care plan problem/need regarding placed in the lock unit as least restrictive approach to protect the resident and assure his/her health and safety.The resident had a 2/17/26 care plan problem/need due to risk for elopement due to exit seeking behaviors.A 12/30/25 admission, MDS assessment indicated the resident was in cognitively, intact, had moderately severe depression and displayed no maladaptive behaviors during the assessment period including wandering.Prior to the 1/27/26 order for the resident to reside on a dementia unit, the clinical record lacked: a. An assessment of the resident's need for a secure dementia unit,b. Documentation regarding a care conference held in conjunction with the resident's representative to address the need for a secured dementia unit,c. An assessment or evaluation completed by the resident's physician, which determined the resident's need for a secured dementia care unit,d. An IDT note which addressed the resident's need for a secured dementia unit.e. Documented incidents of wandering for the period of time from 12/1/25 to 3/16/26.The clinical record indicated the resident's room was not relocated on 1/28/26. The change in the resident's services on 1/28/26 was the unit was locked on that date. During an observation on 3/17/26 at 11:33 a.m., Resident 3 was participating in an activity in the dementia dining room.During an observation on 3/19/26 at 11:22 a.m., the resident was participating in an activity in the dementia unit dining room.A current facility policy titled Resident Rights , last reviewed on January 31, 2026, and provided by the Corporate Nurse Consultant via email on 3/18/26 at 3:26 p.m., indicated the following: .All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility.All residents have the right to be /will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life . These rights include the residents' rights to:.2. Residents are entitled to exercise his or her rights and privileges as a resident of the facility and as a citizen or resident of the United States to the fullest, extent possible without interference, coercion or discrimination or reprisal. A current facility policy titled Dementia Care which was last reviewed January 31, 2026 and provided via email by the Corporate Nurse Consultant on 3/18/26 at 12:50 p.m., indicated the following: .To enhance the quality of life and care for residents with dementia: The goal for our residents with dementia is to provide an environment that upholds their dignity and worth as individuals in an environment that is peaceful, calm, safe and accepting, thus enabling them to reach their full potential Care not only focuses on meeting the physical needs of the resident, but also social, emotional and spiritual, and/or assisting the resident to maintain optimal quality of life through respectful, gentleness and understanding A current facility policy titled Abused, Neglect and Misappropriation of Property which was last reviewed, January 31, 2026 and provided the Interim Administrator via an email on 3/16/26 at 1:51 p.m., indicated the following: .Involuntary seclusion means separation of a resident from other residents or from his or her room or confinement to his or her room, (with or without roommate,)theses against the residents will or the will of the residents legal representative Placement of a cognitively impaired resident on a locked unit for therapeutic and safety reasons is not involuntary seclusion, so long as the residents representative, if any, agrees the placement and is involved in the resident's care, and care and services are provided to the resident in accordance with his or her care plan. The placement of a resident on a locked unit shall be implemented as the least restrictive alternative for the least amount of time necessary to treat the resident's symptoms and protect the resident's safety. 410 IAC (Indiana Administrative Code) 16.2-3.1 -27(1)(4)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self-administration of medication assessment was completed prior to leaving medications unattended in a resident's room for 1 of 8 residents observed for medication administration (Resident 29). Finding includes: During a continuous medication administration observation, beginning on 3/18/26 at 9:12 a.m., RN 3 prepared the following medications for Resident 29: acetaminophen (Tylenol) 325 mg (2 tabs), acetazolamide 250 mg (for fluid retention), bumetanide (for swelling) 1 mg, carvedilol 12.5 mg (for hypertension), multivitamin, ferrous sulfate (iron) 325 mg, omeprazole 40 mg (for gastroesophageal reflux disease) delayed release, and spironolactone 25 mg (for fluid around the lungs). She took the medications into Resident 29's room. Resident 29 questioned why an additional pill was in the medication cup. RN 3 indicated the resident took acetazolamide on Mondays, Wednesdays, and Fridays for the resident's swelling. The resident indicated she did not want to take another water pill. She took enough of them already. RN 3 encouraged the resident to take the medication, and Resident 29 declined. RN 3 was uncertain which of the pills was the acetazolamide. She left the medication cup containing the medications in the resident's room and walked to the medication cart, approximately five feet down the hallway from the resident's doorway. She did not have a line of vision into the resident's room from the medication cart. She obtained the acetazolamide medication card from the medication cart and brought it into the resident's room. The resident poured the medications in the medication cup onto her bedside table and looked through the medications. RN 3 removed the acetazolamide. Then, Resident 29 questioned the identity of each pill. The nurse left the room, went to the medication cart (in the same area as above), and obtained all the medication cards to identify each specific pill. She returned to the resident's room and went over the medications. During an interview, on 3/18/26 at 9:52 a.m., RN 3 indicated she did not think about bringing the medications back out to the cart with her when the resident questioned the medications. If the medications had contained a narcotic, she would not have left the medication unattended with the resident. Resident 29's clinical record was reviewed 3/18/26 at 11:23 a.m. Diagnoses included essential hypertension, pulmonary hypertension (high blood pressure in the lung arteries), pleural effusion (abnormal buildup of fluid around the lungs), acute on chronic systolic (congestive) heart failure, anemia, and gastroesophageal reflux disease without esophagitis. Current orders included the following: acetaminophen 325 mg - two tabs every six hours as needed for mild pain, acetazolamide 250 mg every Monday, Wednesday, and Friday, bumetanide 1 mg daily, carvedilol 12.5 mg twice a day, multivitamin daily, ferrous sulfate 325 mg daily, omeprazole - delayed release 40 mg daily, and spironolactone 25 mg daily. A Minimum Data Set (MDS) assessment, dated 2/26/25, indicated the resident was cognitively intact. The resident's clinical record did not contain a medication self-administration assessment or order. During an interview, LPN 4 indicated medications should not be left in the residents' rooms out of the line of sight unless the resident had a self-administration of medication order. During an interview, LPN 5 indicated medications should not be left unattended at the residents' bedsides. During an interview, the DON indicated medications should not be left with a resident out of the line of sight of the nurse unless the resident had a self-administration of medication order. A current facility policy, dated 2007, titled Storage of Medication, provided by the Corporate Nurse Consultant on 3/19/26 at 2:02 p.m., indicated the following: . The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. A current facility policy, revised 6/24/24, titled Self-Administration Medication, provided by the Corporate Nurse Consultant on 3/19/26 at 2:02 p.m., indicated the following: .Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. 410 IAC (Indiana Administrative Code) 16.2-3.1-11(a)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility failed to promote and protect a resident's right to make choices concerning his personal attire when going outdoors to smoke for 1 of 1 residents reviewed for choices. (Resident 43) Findings include:During an interview on 3/18/26 at 10:48 a.m., Resident 43 indicated on the previous evening (3/17/26 at 4:30 p.m.), the Interim Administrator had informed him he had to wear a hood up to go out to smoke. The resident indicated he did not want to wear a hood, and it was his right to refuse to wear his hood up. He was wearing a hooded coat over a hooded sweatshirt and was dressed for cold weather. The Interim Administrator told him, I make the rules here. The resident indicated the Interim Administrator put hands on me! The Interim Administrator put his hands on the resident's shoulders and yanked the hood up on the resident's head. The resident then pushed the hood down. The Interim Administrator again yanked the hood back up on the resident's head. This action was followed by the resident pushing the hood back down. The Interim Administrator then yanked the hood on the resident's head a third time. The resident indicated he was embarrassed and humiliated by this action and felt he had been treated like a child. Other residents were present and witnessed the action, which increased his embarrassment.Confidential interviews were conducted during the survey.Confidential interviews regarding the smoke break on 3/17/26 at 4:30 p.m. indicated the following:a. The Interim Administrator yanked Resident 43's hood up on his head. The resident pushed the hood back down and the Interim Administrator yanked the hood up a second time. The Interim Administrator treated the resident like he was a child. He put hands on him and that was wrong.b. The Interim Administrator yanked the hood up on Resident 43's head two times. They believed he made the resident feel like he was being treated like a child.c. The Interim Administrator put the hood up on Resident 43's head. The resident indicated to them he felt like he was being treated like a child. Resident 43's clinical record was reviewed on 3/18/26 at 2:01 p.m. Current diagnoses included depression, atrial fibrillation, and chronic obstructive pulmonary disease (COPD).A 2/16/26 Minimum Data Set (MDS) assessment indicated the resident was cognitively intact, had moderate depression, and had not displayed any maladaptive behaviors during the assessment period. The resident had current care plan problems/needs regarding the following:The resident wished to smoke. This care plan problem originated 8/12/25 and was revised 2/25/26. The approach to this care plan problem did not include the need to wear a hood or hat when smoking.The resident was at risk for an altered mental state due to depression. This care plan problem originated 8/12/25 and was revised 2/25/26.The resident displayed verbal expressions of distress related to depression. This care plan problem originated 2/21/26 and was revised on 2/25/26.A 10/22/25 Smoking Assessment indicated the resident was safe to participate in supervised smoking. No section of the assessment indicated a hat or hood should be worn when smoking.A 10/23/25 IDT (Interdisciplinary Team) note indicated the resident had attended a resident council meeting to discuss the smoking policy. A facility abuse investigation Witness Statement, provided by the Corporate Nurse Consultant via email on 3/20/26 at 1:45 p.m., indicated the following: Witness name: [Interim Administrator's name] Witness title: Administrator.On March 17, 2026, the first and second smoke breaks of the day had been canceled due to outside temperatures. Around 4:30 p.m. a few of the smokers approached me about having a 4:30 smoke break, the wind chill was 17. I reluctantly agreed to take them out to have one cigarette if they would agree to wear their heaviest coats and have hats or hoods to protect their head. All that were present agreed. I then went to get the smoking box to distribute cigarettes when I returned and started to distribute cigarettes. [Resident 43's name] joined the group . [Housekeeper 17] assisted me with handing out cigarettes at that time. I reminded all of the residents to put their hoods up before we went outside. [Resident 43] refused to comply and started to self propel towards his room. At that point I turned to him and said you can go back to your room if you want to, but the temperature (sic) going down there most likely (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will not be another smoke break after dinner. He then turned around and accepted a cigarette from [Housekeeper 17] as the residents were being assisted through the doorway, [Resident 43] refused to put his hood up saying that he didn't want to and didn't have to. One of the other residents started to reach over and pull his hood up, and I pulled his it up from the other side. At this point, [C.N.A. 18] from the east wing arrived to supervise, and I headed to stand down meeting. A facility abuse investigation Witness Statement, provided by the Corporate Nurse Consultant via email on 3/20/26 at 1:45 p.m., indicated the following: Witness name: [C.N.A. 18's name]Witness title C.N.A.On March 17, 2026, around 4:30 p.m., I was in the main dining room to see if they needed assistance with taking residents out to smoke. When I came into the dining room, they were heading out the open door to the patio. Cigarettes had already been passed out. I then went out and stayed with the residents. For their smoking times I didn't witness any interaction between [the Interim Administrator] and [Resident 43]. [Resident 43] was complaining and stated that [the Interim Administrator] put his hood on him. He did not say anything about him physically touching him. Untitled documents included in the facility investigation of the allegation of abuse on March 17, 2026, provided by the Corporate Nurse Consultant via email on 3/20/26 at 1:45 p.m., indicated:a. Resident 112's statement: The administrator pulled [Resident 43's] hood up and [resident's name] didn't want it on. [The Interim Administrator] said it was cold out here. You need your hood up on coat. Told him to leave him alone, not abuse , but [Resident 43] has rights, and if he didn't want to wear it , he doesn't have to. b. Resident 46's statement: Put my hood up, which was nice. He asked everybody to put hood up, he didn't do anything wrong. He was not abusive at all, don't know why [Resident 43 and another resident] made a big deal about it. They didn't like anything that's not their idea. A current facility policy titled Resident Rights, last reviewed on January 31, 2026, provided by the Corporate Nurse Consultant via email on 3/18/26 at 3:26 p.m., indicated the following: .All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility.All residents have the right to be /will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life These rights include the residents' rights to: .2. Residents are entitled to exercise his or her rights and privileges as a resident of the facility and as a citizen or resident of the United States to the fullest, extent possible without interference, coercion or discrimination or reprisal. A current facility policy titled Abused, Neglect and Misappropriation of Property which was last reviewed, January 31, 2026, which was provided the Interim Administrator via an email on 3/16/26 at 1:51 p.m., indicated the following: .Mental abuse.Includes, but it's not limited to humiliation, harassment, threats of punishment or deprivation, withholding of goods or services or any other statement or behavior that a reasonable person would consider to be humiliating, demeaning, or threatening to a resident. A facility document titled Resident Council Meeting Minutes, dated October 2025 (Day illegible), provided by the Corporate Nurse Consultant via email on 3/18/26 at 3:26 p.m., indicated the following: .Smoking changes: LOA (leave of absence) Smokers can now go out on the patio and smoke. Just sign out. No one can go outside of the building. More lights are needed on the patio. Supervised smokers stay the same 3 x (times) a day. The notes did not include the need for a hat or hood when smoking in inclement, weather. The document lacked indication that smoking attire was discussed. A current facility policy titled Facility Smoking/Non-Smoking Policy last reviewed January 30, 2026, was provided by the Corporate Nurse Consultant via email on 3/18/26 at 3:26 p.m., and indicated the following: .1. Residents who wish to use smoking products will be evaluated, and this will be documented in the electronic medical record (EMR) .The policy did not address clothing, hats or hoods. 410 IAC (Indiana Administrative Code) 16.2-3.1 - 3(u)(3)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a written notice of transfer/discharge and a bed hold policy were provided to the resident and/or resident representatives and information was communicated to the receiving facility to ensure continuity of care for 3 of 4 resident's reviewed for hospitalization. (Resident's 105, 113, and 30) Findings include: 1.Resident 105's record was reviewed on 3/17/2026 3:38 p.m Medical diagnoses included vascular dementia, chronic kidney disease, and heart failure. A 1/15/26 quarterly Minimum Data Set (MDS) indicated the resident was severely cognitively impaired. A 1/22/26, nurse's note indicated the resident was found pale, hypoxic (low oxygen saturation), and breathing strenuously. 911 was called for transfer to the emergency room (ER). The Physician, facility management, and resident's daughter were made aware of her transfer. A 1/22/26 Change of Condition event note indicated a notice of transfer/discharge was reviewed and given to the resident. The clinical record lacked notification of transfer to the receiving facility and review of the notice of transfer/discharge and bed hold policy with the resident's representative. During an interview on 3/20/26 at 11:36 a.m., the Corporate Nurse Consultant (CNC) indicated when a resident is transferred to a hospital or other facility, staff call report to the receiving facility and provide Emergency Medical Services (EMS) with a continuing care document that includes resident medications, code status, diagnoses, and the most recent set of vital signs. A notice of transfer/discharge is reviewed with and provided to the resident. If a resident is not cognitively intact, the notice of transfer/discharge and bed hold policy are reviewed and sent with/to the resident's representative. 2.Resident 113's record was reviewed on 3/17/26 at 3:48 p.m. Diagnoses included multiple sclerosis, pneumonia, other disorders of the lung, severe protein-calorie malnutrition, dysphagia, pharyngeal phase, and adult failure to thrive. A 1/16/26 quarterly MDS assessment indicated the resident was cognitively intact. A nurse's note, on 3/3/26 at 11:00 p.m., indicated the staff entered the resident's room and found the resident lethargic, with facial drooping, increased confusion, and weakness. The nurse practitioner (NP) was notified and issued new orders to transfer the resident to the hospital for evaluation and treatment. The resident's representative was informed. The clinical record lacked notification of the transfer to the receiving facility and review of the notice of transfer/discharge and bed hold policy with the resident or the resident's representative. During an interview, on 3/20/26 at 9:59 a.m., LPN 4 indicated when a resident was sent to the hospital, the physician, family, and hospital were notified. The resident's face sheet, a continuity of care document that included orders and code status, were sent with the resident. The bed hold and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer/discharge notice was reviewed with the resident and sent along as well. A hospital transfer sheet was documented in the record and contained all the aforementioned information. During an interview, on 3/20/26 at 10:17 a.m., LPN 16 indicated when a resident was transferred to the hospital, the physician was notified for an order, transportation was notified, and the receiving hospital was notified and given a report of the resident's condition. A bed hold and the transfer/discharge paperwork were filled out and signed by the resident or the resident's power of attorney (POA) if the resident was cognitively impaired. The paperwork was copied and given to the resident or POA and the emergency medical technicians. The resident's condition, the physician notification, the family notification, and the hospital notification was documented. During an interview, on 3/20/26 at 10:20 a.m., LPN 5 indicated when a resident was transferred to the hospital, the physician was notified, the family was notified, an SBAR (situation, background, assessment, recommendation) form was filled out, and a transfer to hospital and bed hold policy were completed with the resident. 3.Resident 30's clinical record was reviewed on 3/18/26 at 1:06 p.m. Diagnoses included right sided hemiplegia (paralysis) and hemiparesis (weakness) following cerebrovascular disease, type 2 diabetes mellitus, and chronic congestive heart failure. A 12/21/25, quarterly MDS assessment indicated the resident was cognitively intact. A 3/15/26, discharge MDS assessment indicated the resident discharged with a return anticipated. A 3/15/26, progress note indicated the resident was found on the floor. Resident 30 was yelling out in pain and unable to verbalize how she fell. Her speaking was mumbled and non-sensical. She was unable to follow basic instructions. Resident 30 was sent to the hospital for evaluation and treatment. The facility director, physician, and the resident's family were notified. A 3/15/26, fall event note, indicated the resident reported pain and hitting her head and teaching would occur upon return from the hospital. A 3/15/26, online e-Interact Nursing Home to Hospital Transfer Form indicated the resident was sent to the emergency room. The form lacked a resident or resident representative signature. The clinical record lacked indication the resident and/or resident representatives were provided with a copy of the notice of transfer/discharge form and/or the bed hold policy. During an interview, on 3/20/26 at 1:01 p.m., the CNC indicated she was unable to locate the notice of transfer/discharge forms or bed hold policies provided to residents and/or resident representatives requested. A current facility policy titled, Transfer/Discharge Notice, revised 2/3/2025, and provided by the CNC on 3/20/26, indicated the following: . This policy establishes procedures to ensure appropriate notice, documentation, and support for safe and orderly transitions.2. Documentation: When a resident transfers or discharges: v. Information provided to the receiving provider should include the following: When the facility transfers or discharges a resident, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. 1. Information provided to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receiving provider must include a minimum of the following: a. Contact information of the practitioner responsible for the care of the resident; b. Resident representative information including contact information; c. Advance Directive information d. All special instructions or precautions for ongoing care, as appropriate; e. Comprehensive care plan goals; and f. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.7. Before a facility transfers or discharges a resident: 1. Notify the resident and resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.8. Timing of the Notice: .b. Notice must be made as soon as practicable before transfer or discharge when-.iv. An immediate transfer or discharge is required by the resident's urgent medical needs.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to ensure a baseline care plan was completed for 1 newly admitted resident of 2 residents reviewed for tube feeding. (Resident 47)Finding includes: Resident 47's clinical record was reviewed on 3/17/26 at 3:18 p.m. Diagnoses included acute pancreatitis without necrosis or infection, gastrostomy status, and unspecified protein-calorie malnutrition.Current physician orders included enteral feeding tube site care- cleanse site with normal saline and cover with dry dressing once daily (3/13/26) and Jevity 1.5 (feeding tube nutrition) 52 ml per hour via feeding tube to run every shift when not eating during meal service (3/13/26).The clinical record lacked a baseline care plan.A 3/5/26, progress note indicated the resident admitted to the facility with a feeding tube in place.During an interview on 3/20/26 at 1:06 p.m., LPN 14 indicated she was uncertain who was responsible for completion of residents' baseline care plans for new admissions.On 3/20/26 at 1:10 p.m., RN 15 indicated the admitting nurse was required to follow the new admission assessment checklist which included the baseline care plan. If the admitting nurse did not get the baseline care plan finished, the next shift nurse was required to ensure it was completed within 24 hours. Upon finishing the baseline care plan and new admission checklist, they were given to the Unit Manager or placed in the Unit Manager's mailbox. It was not acceptable when the resident's baseline care plan was incomplete.On 3/20/26 at 1:22 p.m., the Corporate Nurse Consultant indicated the facility was unable to provide a baseline care plan for Resident 47. The baseline care plan should have been completed within 48 hours of admission.A current facility policy, reviewed 1/31/25, titled Baseline Care Plan Policy, provided by the Corporate Nurse Consultant on 3/20/26 at 11:27 a.m., indicated the following: Policy Statement Plan is developed and implemented to promote continuity of care and communication among facility stakeholders to increase resident safety and safeguard against adverse events that are most likely to occur right after admission. GUIDELINE: 1. The Baseline Care Plan will be developed and implemented within 48 hours of a resident's admission.410 IAC (Indiana Administrative Code)16.2-3.1-30(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on interview, observation, and record review, the facility failed to provide services to prevent complications related to clogging and skin impairment around the insertion site for a resident with a feeding tube for 1 of 2 residents reviewed for tube feeding. (Resident 47)Finding includes: During an interview on 3/17/26 at 10:57 a.m., Resident 47 indicated she had a feeding tube and only received her tube feeding through the night. She took her medications by mouth and ate some food by mouth, but it was painful to eat. The facility staff managed her feeding tube. They performed feeding tube site care every other day. Resident 47's clinical record was reviewed on 3/17/26 at 3:18 p.m. Diagnoses included acute pancreatitis without necrosis or infection, gastrostomy status, and unspecified protein-calorie malnutrition.Current physician orders included enteral feeding tube site care- cleanse site with normal saline and cover with dry dressing once daily (3/13/26) and Jevity 1.5 (feeding tube nutrition) 52 ml per hour via feeding tube to run every shift when not eating during meal service (3/13/26). A 3/10/26, admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. Nutritional approaches lacked a feeding tube on the admission assessment. The resident required set-up assistance from staff for eating. A current care plan, dated 3/6/26, indicated the resident was at risk for complications related to the feeding tube enteral feeding. Interventions included the following: provide skin care to the insertion site as needed (3/6/26) and report complications to the MD (3/6/26).A 3/5/26, progress note indicated the resident arrived at the facility with a feeding tube to the abdomen. The feeding tube insertion site lacked any signs of infection.A progress note, dated 3/11/26 at 8:00 a.m., indicated the resident's feeding tube was clogged. Attempts were made to flush the feeding tube with warm water and a 60 ml syringe using a gentle push-pull technique and de-clogger which were unsuccessful. On 3/11/26 at 9:15 p.m., the resident's clogged feeding tube was flushed using the gentle push-pull technique and flushed with ease. The clinical record lacked the following: physician notification of the resident's g-tube being clogged, orders to unclog the feeding tube, documentation of changes to the feeding tube site, and physician notification of the feeding tube site drainage, tenderness, and redness. During an observation on 3/19/26 from 8:11 p.m. to 8:27 p.m., RN 13 entered the resident's room to provide feeding tube site care. No feeding was running during the observation. RN 13 performed hand hygiene and donned a pair of gloves. Resident 47's feeding tube split gauze dressing contained tan drainage and was dated 3/19/26. The feeding tube insertion site had redness noted approximately one fourth of an inch out and surrounding the feeding tube. RN 13 placed normal saline (wound cleanser) on gauze and cleansed from the insertion site outward. The resident was guarded and told the nurse the site was tender during feeding tube site care. The resident indicated the rubber bumper on the feeding tube had moved outward and had previously been directly against her abdomen. The rubber bumper had half an inch gap between the resident's skin during the observation. The feeding tube tenderness and redness was new. During an interview, RN 13 indicated she needed to report the drainage, redness and tenderness to the physician since the resident indicated this was a change from her normal baseline. During an interview on 3/20/26 at 10:07 a.m., LPN 14 indicated she had taken report from RN 13 when she began her shift at 7:00 a.m. RN 13 had not reported any concerns about Resident 47's feeding tube. She was unable to find anything in the clinical record regarding a change in condition of the resident's feeding tube site or physician notification of any concerns regarding the resident's feeding tube site. Drainage, redness, and tenderness at the tube feeding insertion site should have been reported to the physician immediately, passed on in report to the next nurse for continuity of care, and documented in the resident's clinical record. Upon review of the 700 Unit Report Sheet from RN 13, LPN 14 indicated no concerns were written on the report sheet. Failure to report concerns regarding the feeding tube could result in an untreated infection. On 3/20/26 at 10:25 a.m., the Infection Preventionist (IP) indicated any change in condition related to the feeding tube (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such as clogging, redness, tenderness, and drainage should have been reported immediately to the physician and documented in the resident's clinical record. A tube feeding policy was requested.A facility policy for feeding tubes was not provided prior to facility exit on 3/20/26.A current facility policy, revised 1/31/25, titled Skin Integrity,, provided by the Corporate Nurse Consultant on 3/20/26 at 11:25 a.m., indicated the following: .The facility will ensure that.1. A resident receives care, consistent with professional standards of practice, to prevent avoidable skin integrity issues and does not develop avoidable skin integrity issues unless the individual's clinical condition demonstrates that they were unavoidable; and 2. A resident with impaired skin integrity receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent avoidable skin integrity issues from developing. Procedure 3. Recommend ongoing observation of skin integrity by licensed nursing staff. 4. The licensed nurse shall initiate applicable Skin Integrity documentation if a new area of impairment is identified. A current facility policy, reviewed on 1/31/26, titled Notification of Change of Condition, provided by the Corporate Nurse Consultant on 3/20/26 at 11:25 a.m., indicated the following: POLICY. To ensure appropriate individuals are notified of changes in condition. GUIDELINES. 2. Documentation of notification or notification attempts should be recorded in the resident electronic medical record. 3. The resident and/or representative (if applicable), and medical provider should be notified of a change in condition. The medical provider will provide guidance related to the change in condition.410 IAC (Indiana Administrative Code) 16.2-3.1-44(a)(2)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post current and accurate nursing staff information daily for residents and visitors. This deficiency had the potential to affect 114 of 114 residents in the facility.Findings include:During an observation on 3/16/26 at 9:23 a.m., the facility nurse staffing, dated 3/11/26, was posted on a clipboard at the front receptionist desk. The nursing staff posting, dated 3/11/26, included the following:Census: 116 Number of Registered Nurses (RN): Day shift hours: 15.50, Evening shift hours: 9.00, Night shift hours: 0.00, and Total hours: 24.50.Number of Licensed Practical Nurses (LPN): Day shift hours: 24.00, Evening shift hours: 29.50, Night shift hours: 30.00, and Total hours: 83.50. Number of Certified Nursing Assistant (CNA): Day shift hours: 72.50, Evening shift hours: 47.00, Night shift hours: 43.50, and Total hours: 163.00.During an observation on 3/17/26 at 9:55 a.m., the facility nurse staffing, dated 3/17/26, was posted on a clipboard at the front receptionist desk. The nursing staff posting, dated 3/17/26, included the following:Census: 83 Number of Registered Nurses (RN): Day shift hours: 22.00, Evening shift hours: 9.50, Night shift hours: 24.00, and Total hours: 55.50.Number of Licensed Practical Nurses (LPN): Day shift hours: 8.50, Evening shift hours: 14.00, Night shift hours: 1.00, and Total hours: 23.50. Number of Certified Nursing Assistant (CNA): Day shift hours: 69.00, Evening shift hours: 70.50, Night shift hours: 41.50, and Total hours: 181.00.During an interview, on 3/20/26 at 1:30 p.m., the Scheduler indicated he was new to the position, and this was his first week. His shift started as early as 6:30 a.m. and he utilized an online system that populated the staff posting form. He indicated he intended to prepare the daily staff posting the night before, as he was leaving. The staff posting needed to be current and accurate. The census number and hours worked for each nursing position was included, such as Registered Nurse (RN), Licensed Practical Nurse (LPN), and Certified Nursing Assistant (CNA). He planned to print the staff posting for the weekends on Friday evenings and have the weekend manager ensure the correct day is available to residents and visitors.During an interview, on 3/20/26 at 1:30 p.m., the Corporate Nurse Consultant indicated the staff posting should have been updated daily from 3/11/26 through 3/16/26. The facility would not have had accurate staff posting available to residents or visitors over the weekend. The staff posting for 3/18/26 should have contained an accurate census number. The facility utilizes an online system to populate the staff posting forms and she would need to ensure the system was updating appropriately.A current facility policy, revised 1/30/26, provided by the Corporate Nurse Consultant on 3/20/26 at 11:30 a.m., indicated the following: . 1. On a daily basis, at the beginning of the shift, the facility must have posted or available for review the following data. 2. The facility will post the following information on a daily basis: Facility name, the current date, the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: a. registered nurses, b. licensed practical nurses or licensed vocational nurses, and c. certified nurse aides., and the Resident census. 3. The facility will post the nurse staffing data mentioned above daily at the beginning of each shift.

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	03/20/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies.Findings include:Review of the Summary Statement of Deficiencies, for the facility's last annual recertification and licensure survey completed on January 23, 2025, indicated the facility had deficiencies related to failure to ensure the self-administration of medications assessment was completed prior to medications being left unattended in a resident's room.During an interview, on 3/20/26 at 2:03 p.m., the VP of Operations indicated the Quality Assessment and Assurance (QAA) committee met quarterly to review current facility concerns. The QAA committee utilized an online program to assist with streamlining the process, assessing trends, and documentation of these meetings. The areas of concern cited previously in a survey would be followed per the plan of correction, which was usually for a period of six (6) months. If the audit tools indicated continued deficiency, then the facility would extend the time frame this area was reviewed. However, if the audit tools showed compliance with the regulation, then the reviews would end.During an interview, on 3/20/26 at 2:03 p.m., the Corporate Nurse Consultant indicated the company completed mock surveys and paid special attention to the areas previously cited in surveys to ensure continued compliance. The facility did not have any current QAPI or Performance Improvement Plans (PIP's) in place for ensuring self- administration assessments were completed prior to medications being left unattended in a resident's room.Repeat concerns regarding self-administration of medications were cited during the March 20, 2026, survey as follows:Based on observation, interview, and record review, the facility failed to ensure a self-administration of medication assessment was completed prior to leaving medications unattended in a resident's room for 1 of 8 residents observed for medication administration (Resident 29). A current facility policy, revised 1/31/26, titled, Quality Assurance/Performance (QAPI) Program Policy, provided by the Corporate Nurse Consultant on 3/16/26 at 2:01p.m., indicated the following: . It is the intent of this facility to conduct an on-going Quality Assurance/Performance Improvement (QAPI) program designed to systematically monitor, evaluate and improve the quality and appropriateness of resident care. QAPI supports the overall goals of the facility and examines both outcomes and processes relevant to these outcomes with the objective of improving the organization's overall performance with addressing care and management systems. 6. The facility will identify areas for QAPI monitoring and tools/resources to be utilized. These monitoring activities should focus on those processes that significantly affect resident outcomes. 7. The QAPI committee will review, and coordinate audits and assessments based on the QAPI. Completion of additional audits and assessments will be determined by concerns identified through the QAPI committee. d. Problem areas - the aspect of care has tended in the past to produce problems for staff or residents. Cross reference F554 410 IAC (Indiana Administrative Code) 16.2-3.1-52(b)(2)

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	03/20/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview, observation, and record review, the facility failed to follow enhanced barrier precautions during feeding tube site care for 1 of 2 residents reviewed for tube feeding. (Resident 47)Finding includes: During an interview on 3/17/26 at 10:57 a.m., Resident 47 indicated staff managed her feeding tube. Staff did not wear a gown over their clothing when they manipulated her feeding tube.Resident 47's clinical record was reviewed on 3/17/26 at 3:18 p.m. Diagnoses included acute pancreatitis without necrosis or infection, gastrostomy status, and unspecified protein-calorie malnutrition.Current physician orders included enteral feeding tube site care- cleanse site with normal saline and cover with dry dressing once daily (3/13/26) and enhanced barrier precaution every shift (3/9/26).A 3/10/26, admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact.A current care plan, dated 3/16/26, indicated the resident required enhanced barrier precautions related to enteral feeding. Interventions included personal protective equipment as indicated (3/16/26). During an observation on 3/19/26 from 8:11 p.m. to 8:27 p.m., RN 13 entered the resident's room to provide feeding tube site care. An enhanced barrier precaution sign was in place to the left of the door and a canister below it contained personal protective equipment readily available. RN 13 performed hand hygiene and donned a pair of gloves. Resident 47's feeding tube split gauze dressing contained tan drainage and was dated 3/19/26. RN 13 removed the split gauze dressing with both hands and placed it into the trash along with the dirty gloves. Hand hygiene was not completed. The feeding tube insertion site had redness noted approximately one fourth of an inch out surrounding the feeding tube. RN 13 donned a clean set of gloves and performed feeding tube site care by placing normal saline (wound cleanser) on gauze and cleansed from the insertion site outward. RN 13 leaned in against the resident's bed sheet and blanket with her right pant leg as she placed the new split gauze dressing at the insertion site. A gown was not worn by RN 13 during the feeding tube site care.During an interview on 3/19/26 at 8:28 p.m., RN 13 indicated she did not wear a gown during the resident's feeding tube site care. She did not notice the enhanced barrier precaution sign to the left of the door until she exited the room. Enhanced barrier precautions were required for residents with medical devices to prevent contamination and infections.On 3/20/26 at 10:25 a.m., the Infection Preventionist (IP) indicated EBP was required for any manipulation of the feeding tube. A gown and gloves were required during feeding tube care. A current facility policy, reviewed 1/31/26, titled Enhanced Barrier Precautions, provided by the Corporate Nurse Consultant on 3/20/26 at 11:26 a.m., indicated the following: . This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Guideline 2. Enhanced Barrier Precautions (EBP) are additional measure to attempt to decrease transmission of Multidrug-Resistant Organisms (MDRO). 5. EBP are indicated for residents who have chronic wounds and or indwelling medical devices regardless of MDRO status. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(a)