| STATEMENT OF DEFICIENCIES |   | X1) PROVIDER/SUPPLIER/CLIA        | (X2) M  | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY |            |
|---------------------------|---|-----------------------------------|---------|----------------------------|---|------------------|------------|
| AND PLAN OF CORRECTION    |   | IDENTIFICATION NUMBER             | A. BU   | A. BUILDING <u>00</u>      |   | COMPLETED        |            |
| 155400                    |   | 155400                            | B. WING |                            |   | 05/27/2025       |            |
|                           |   |                                   |         | CTREET                     | ADDRESS, CITY, STATE, ZIP COD                                       |                  |            |
| NAME OF P                 | ROVIDER OR SUPPLIER   |                                   |         |                            | JACKSON ST  |                  |            |
| CAPDINI                   | AL CARE STRATEO   | SIES                              |         |                            | E, IN 47303   |                  |            |
| CANDINA                   | AL CARE STRATEC   | 31E3                              |         | MONCI                      | E, IN 47303   |                  |            |
| (X4) ID                   | SUMMARY S   | STATEMENT OF DEFICIENCIE          | ID      |                            | PROVIDER'S PLAN OF CORRECTION                                       |                  | (X5)       |
| PREFIX                    | (EACH DEFICIEN  | CY MUST BE PRECEDED BY FULL       |         | PREFIX                     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG                       | REGULATORY OR   | LSC IDENTIFYING INFORMATION       |         | TAG                        | DEFICIENCY)   |                  | DATE       |
| F 0000                    |   |                                   |         |                            |   |                  |            |
|                           |   |                                   |         |                            |   |                  |            |
| Bldg. 00                  |   |                                   |         |                            |   |                  |            |
|                           | This visit was for th   | e Investigation of Complaints     | F 00    | 000                        | June 13, 2025   |                  |            |
|                           | IN00459988, IN004   | 458991, and IN00458662.           |         |                            |   |                  |            |
|                           |   |                                   |         |                            | Ms. Suzanne Williams  |                  |            |
|                           | Complaint IN00459   | 988 - No deficiencies related to  |         |                            | Director of Long Term Care  |                  |            |
|                           | the allegations are c   |                                   |         |                            | 2 North Meridian St.  |                  |            |
|                           | _   |                                   |         |                            | Indianapolis, IN 46204  |                  |            |
|                           | Complaint IN00458   | 1991 - No deficiencies related to |         |                            |   |                  |            |
|                           | the allegations are c   | ited.                             |         |                            | Re: Survey Event ID 300611  |                  |            |
|                           | -   |                                   |         |                            |   |                  |            |
|                           | Complaint IN00458662 - Federal/State deficiencies related to the allegations are cited at F600, F607, |                                   |         |                            | Dear Ms. Williams:  |                  |            |
|                           |   |                                   |         |                            |   |                  |            |
|                           | and F610.   |                                   |         |                            | Please find attached my Plan  | 1                |            |
|                           |   |                                   |         |                            | of Correction for deficiencies                                      |                  |            |
|                           | Survey dates: May   | 23 and 27, 2025                   |         |                            | cited during a complaint  |                  |            |
|                           |   |                                   |         |                            | survey. I am respectfully   |                  |            |
|                           | Facility number: 00   | 0269                              |         |                            | requesting paper compliance   | <b>)</b> .       |            |
|                           | Provider number: 1:   | 55400                             |         |                            |   |                  |            |
|                           | AIM number: 10020   | 67720                             |         |                            | If you have any questions,  |                  |            |
|                           |   |                                   |         |                            | please feel free to contact me                                      | е.               |            |
|                           | Census Bed Type:  |                                   |         |                            |   |                  |            |
|                           | SNF/NF: 74  |                                   |         |                            | Sincerely,  |                  |            |
|                           | Total: 74   |                                   |         |                            |   |                  |            |
|                           |   |                                   |         |                            | Shannon Harris  |                  |            |
|                           | Census Payor Type:  | :                                 |         |                            | Administrator   |                  |            |
|                           | Medicare: 1   |                                   |         |                            |   |                  |            |
|                           | Medicaid: 65  |                                   |         |                            |   |                  |            |
|                           | Other: 8  |                                   |         |                            |   |                  |            |
|                           | Total: 74   |                                   |         |                            |   |                  |            |
|                           |   |                                   |         |                            |   |                  |            |
|                           | These deficiencies r  | reflect State Findings cited in   |         |                            |   |                  |            |
|                           | accordance with 410   | 0 IAC 16.2-3.1.                   |         |                            |   |                  |            |
|                           |   |                                   |         |                            |   |                  |            |
|                           | Quality review com  | pleted May 29, 2025.              |         |                            |   |                  |            |
|                           |   |                                   |         |                            |   |                  |            |
| F 0600                    | 483.12(a)(1)  |                                   |         |                            |   |                  |            |
| SS=D                      | Free from Abuse a   | and Neglect                       |         |                            |   |                  |            |
| Bldg. 00                  |   |                                   |         |                            |   |                  |            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Shannon Harris

Administrator

06/25/2025

Any definencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determing the safegaurds provide sufficient protection to the patients (see instructions.) Except for pursing homes, the findings stated above are disclosable.

other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 300611 Facility ID: 000269 If continuation sheet Page 1 of 9

| STATEMENT OF DEFICIENCIES |                      | X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE CONSTRUCTION |                             | ONSTRUCTION   | (X3) DATE SURVEY |            |
|---------------------------|----------------------|---|----------------------------|-----------------------------|---|------------------|------------|
| AND PLAN OF CORRECTION    |                      | IDENTIFICATION NUMBER                                     | A. BUILDING <u>00</u>      |                             | COMPLETED   |                  |            |
| 1554                      |                      | 155400  | B. WING                    |                             |   | 05/27/2025       |            |
|                           |                      |   |                            | STREET                      | ADDRESS, CITY, STATE, ZIP COD   | <u> </u>         |            |
| NAME OF F                 | PROVIDER OR SUPPLIER | L   |                            |                             | JACKSON ST  |                  |            |
| CARDINA                   | AL CARE STRATE(      | GIES  |                            |                             | IE, IN 47303  |                  |            |
|                           | T                    |   |                            |                             | 1   |                  | T          |
| (X4) ID                   |                      | STATEMENT OF DEFICIENCIE                                  |                            | ID                          | PROVIDER'S PLAN OF CORRECTION   |                  | (X5)       |
| PREFIX                    | `                    | CY MUST BE PRECEDED BY FULL                               |                            | PREFIX                      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE               | COMPLETION |
| TAG                       |                      | LSC IDENTIFYING INFORMATION                               | F ^                        | TAG                         |   |                  | DATE       |
|                           |                      | s and record review, the facility                         | F 00                       | 600                         | F600  |                  | 06/09/2025 |
|                           |                      | esident's right to be free from                           |                            |                             |   | 1-               |            |
|                           | for abuse. (QMA 1    | f for 1 of 3 residents reviewed                           |                            |                             | It is the practice of this facility protect our residents from abu                    |                  |            |
|                           | 101 abuse. (QIVIA I  | , Resident D)   |                            |                             | and neglect.  | ise              |            |
|                           | Findings include:    |   |                            |                             | and neglect.  |                  |            |
|                           | i maniga metude.     |   |                            |                             | 1 – What corrective action will   | he               |            |
|                           | The clinical record  | for Resident D was reviewed                               |                            |                             | accomplished for those reside   |                  |            |
|                           |                      | a.m. Diagnoses included                                   |                            |                             | found to have been affected b   |                  |            |
|                           |                      | rulsions, morbid severe                                   |                            |                             | deficient practice:   | ,                |            |
|                           | _                    | ar hypoventilation, and                                   |                            |                             | a Upon notification of allege   | ed               |            |
|                           | hypertension.        | ,   |                            |                             | deficient investigation, the fac  |                  |            |
|                           |                      |   |                            |                             | policy and procedures for   | ,                |            |
|                           | Review of a facility | self-reportable incident report,                          |                            |                             | allegations of abuse were revi  | ewed             |            |
|                           | dated 4/9/25, indica | ted on 4/9/25 at approximately                            |                            |                             | and updated.  |                  |            |
|                           | 5:30 a.m., QMA 1 v   | was overheard using                                       |                            |                             | b A checklist was updated t   | 0                |            |
|                           | inappropriate langu  | age in a disrespectful manner                             |                            |                             | be completed for investigation  | ıs.              |            |
|                           |                      | incident was reported to the                              |                            |                             | c LPN #2, LPN #1, and C.N   | N.A.             |            |
|                           | State on 4/9/25 at 1 | 0:39 a.m.   |                            | #3 were in-serviced 5/27/25 |   |                  |            |
|                           |                      |   |                            |                             | regarding the facility policy an  | d                |            |
|                           |                      | statement by LPN 2, dated                                 |                            |                             | procedures for allegations of   |                  |            |
|                           |                      | e heard QMA 1 tell Resident D                             |                            |                             | abuse which includes the  |                  |            |
|                           |                      | your f king room". Resident                               |                            |                             | immediate notification of   |                  |            |
|                           |                      | was crying. QMA 1 left the                                |                            |                             | Administrator and DON.  |                  |            |
|                           |                      | got to the resident's room.                               |                            |                             | d Q.M.A. #1 employment w  |                  |            |
|                           | 1                    | "I'm done. He is a f king d -                             |                            |                             | terminated based on investiga   | ition.           |            |
|                           |                      | ed she spent approximately the resident and tried to calm |                            |                             | 2 How other residents to the  | a the            |            |
|                           |                      | entered the resident's room and                           |                            |                             | 2 – How other residents havin   |                  |            |
|                           |                      | nelp calm him down.                                       |                            |                             | potential to be affected by the   |                  |            |
|                           | stayed with him to i | help cann inni down.                                      |                            |                             | same deficient practice will be identified and what corrective                        | ;                |            |
|                           | During an interview  | on 5/27/25 at 10:54 a.m., LPN                             |                            |                             | action(s) will be taken:  |                  |            |
|                           | _                    | 5 at approximately 5:30 a.m.,                             |                            |                             | donon(s) will be taken.   |                  |            |
|                           |                      | A 1 yelling and using                                     |                            |                             | a All residents have the  |                  |            |
|                           | ,                    | age at the resident. She                                  |                            |                             | potential to be affected by the   |                  |            |
|                           |                      | 's room and QMA 1 left. She                               |                            |                             | alleged deficient practice.   |                  |            |
|                           |                      | nt was upset and crying. The                              |                            |                             | g = = = = = = = = = = = = = = = = = = =   |                  |            |
|                           |                      | MA 1 should not have spoken                               |                            |                             | 3 – What measures will be pu  | t                |            |
|                           |                      | N 2 did not report this incident                          |                            |                             | into place and what systemic  |                  |            |
|                           |                      | ely. She indicated QMA 1 had                              |                            |                             | changes will be made to ensu  | re               |            |

| CENTERS FO   | R MEDICARE & MEDIC                              | CAID SERVICES                     |                            |                       |  | OMB NO. 0938-039 |            |
|--|---|-----------------------------------|----------------------------|-----------------------|--|------------------|------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) M                            | (X2) MULTIPLE CONSTRUCTION |                       |  | (X3) DATE SURVEY |            |
| AND PLAN OF CORRECTION IDEN                          |   | IDENTIFICATION NUMBER             |                            | A. BUILDING <u>00</u> |  |                  | LETED      |
|  | 155400  |                                   | B. W                       | ING                   |  | 05/27            | /2025      |
|  |   | <u> </u>                          |                            | CTDEET                | ADDRESS, CITY, STATE, ZIP COD                                      |                  |            |
| NAME OF  | PROVIDER OR SUPPLIE                             | R                                 |                            |                       | JACKSON ST   |                  |            |
| CARDIN   | IAL CARE STRATE                                 | GIES                              |                            |                       | IE, IN 47303   |                  |            |
| (X4) ID  | SUMMARY   | STATEMENT OF DEFICIENCIE          | ı                          | ID                    | 1  |                  | (X5)       |
| PREFIX   |   | NCY MUST BE PRECEDED BY FULL      |                            | PREFIX                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |                  | COMPLETION |
| TAG  | ` `   | R LSC IDENTIFYING INFORMATION     |                            | TAG                   | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   | TE               | DATE       |
| 1110   | <u> </u>  | e felt the resident was safe.     |                            | 1110                  | that the deficient practice does                                   | s not            | DiffE      |
|  |   | room and stayed with the          |                            |                       | recur:   | 3 1101           |            |
|  | resident until they                             | _                                 |                            |                       | a An in-service was comple   | ted              |            |
|  | Testaent until they                             | sumica do wii.                    |                            |                       | on 5/28/25 by the Administrate                                     |                  |            |
|  | CNA 3 was not ava                               | ailable for interview during the  |                            |                       | and Director of Nursing and  | OI .             |            |
|  | survey.   | and the for interview during the  |                            |                       | Assistant Director of Nursing v                                    | with             |            |
|  | Survey.   |                                   |                            |                       | management staff who can as  |                  |            |
|  | OMA 1's employm                                 | ent was terminated and not        |                            |                       | with an investigation including                                    |                  |            |
|  |   | iew during the survey.            |                            |                       | not limited to allegations of                                      | Dut              |            |
|  | available for interv                            | iew during the survey.            |                            |                       | abuse. This included the review                                    | ow of            |            |
|  | During an interview                             | v on 5/27/25 at 11:30 a.m.,       |                            |                       | the facility policy and procedu                                    |                  |            |
|  | _   | ed QMA 1 had yelled and           |                            |                       | for allegations of abuse which                                     |                  |            |
|  |   | use his floor was dirty. The      |                            |                       | included immediate notificatio                                     |                  |            |
|  | incident made him                               |                                   |                            |                       | Administrator and DON. The   | 11 01            |            |
|  | merdent made mm                                 | icer bad .                        |                            |                       | review of the checklist was als                                    | 20               |            |
|  | During an interview                             | v on 5/27/25 at 11:54 a.m., the   |                            |                       | reviewed with the Managemen  |                  |            |
|  | _   | r she became aware of the         |                            |                       | Staff.   | i it             |            |
|  |   | with the resident. The resident   |                            |                       | b An in-service was comple   | tod              |            |
|  |   | d hurt his feelings and made      |                            |                       | on 5/28/2025 for nursing staff                                     |                  |            |
|  | him cry.  | a nart ins reenings and made      |                            |                       | Administrator and DON in reg                                       | -                |            |
|  | inni ory.                                       |                                   |                            |                       | to the facility policy and   | ara              |            |
|  | During an interview                             | v on 5/27/25 at 12:34 p.m., the   |                            |                       | procedures for allegations of                                      |                  |            |
|  | _   | arrived at the facility at around |                            |                       | abuse which included immedia                                       | ate              |            |
|  |   | y in question and was informed    |                            |                       | notification of Administrator ar                                   |                  |            |
|  |   | Jnit Manager 4 on 4/9/25 at       |                            |                       | DON.   | Iu               |            |
|  |   | 00 a.m. She immediately informed  |                            |                       | 5014.  |                  |            |
|  |   | and initiated an investigation.   |                            |                       | 4 – How the corrective action(                                     | (c)              |            |
|  |   | s no longer employed at the       |                            |                       | will be monitored to ensure the                                    |                  |            |
|  | _   | able to be reached for interview  |                            |                       | deficient practice will not recui                                  |                  |            |
|  | during the survey.                              | adio to de reactica for interview |                            |                       | i.e, what quality assurance  | ٠,               |            |
|  | ading die buivey.                               |                                   |                            |                       | program will be put into place:                                    | ·a               |            |
|  | During an interview                             | v on 5/27/25 at 2:23 p.m., both   |                            |                       | The Administrator and/or Desi                                      |                  |            |
|  | _   | and DON indicated LPN 2           |                            |                       | will conduct an audit of all                                       | igi ice          |            |
|  |   | liately informed the              |                            |                       | investigations for thoroughnes                                     | e of             |            |
|  |   | N of the incident and QMA 1       |                            |                       | following the facility policy and                                  |                  |            |
|  |   | ent home immediately.             |                            |                       | procedures, including but not                                      | 4                |            |
|  | Should have been so                             | ent nome miniediately.            |                            |                       | limited to allegations of abuse                                    |                  |            |
|  | A current notion de                             | ated 2/1/2023 titled "Abuse       |                            |                       | Dates and time of notifications                                    |                  |            |
|  | A current policy, dated 2/1/2023, titled "Abuse |                                   |                            |                       | L pares and mine of nomineations                                   | VVIII            | 1          |

Prevention and Prohibition Policy" was provided

by the Administrator on 5/27/25 at 11:40 a.m. The

be documented on the

investigation as well. This will be

PRINTED: 07/01/2025 FORM APPROVED

| CENTERS FOR  | R MEDICARE & MEDIC    | AID SERVICES                             |             |   | OMB NO. 0938-039 |
|--|-----------------------|--|-------------|---|------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                       | (X2) MULTIPLE C                          | ONSTRUCTION | (X3) DATE SURVEY  |                  |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400  |                       | A. BUILDING                              | 00          | COMPLETED<br>05/27/2025   |                  |
|  |                       | B. WING                                  |             |   |                  |
|  |                       |  |             |   | <u> </u>         |
| NAME OF P  | ROVIDER OR SUPPLIER   | 8  |             | ADDRESS, CITY, STATE, ZIP COD   |                  |
|  |                       |  |             | JACKSON ST  |                  |
| CARDINA  | AL CARE STRATE        | GIES                                     | MUNC        | IE, IN 47303  |                  |
| (X4) ID  | SUMMARY               | STATEMENT OF DEFICIENCIE                 | ID          |   | (X5)             |
| PREFIX   | (EACH DEFICIEN        | ICY MUST BE PRECEDED BY FULL             | PREFIX      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION       |
| TAG  | ,                     | R LSC IDENTIFYING INFORMATION            | TAG         | CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)  | DATE             |
|  | policy indicated the  |  |             | monitored 2 times per week fo   |                  |
|  |                       | e the resident's right to remain         |             | weeks, then 1 time per week f   | I                |
|  | -                     | xual, physical, and mental               |             | weeks and then monthly for th   | I                |
|  | abuse, mistreatmen    |  |             | -   | ie               |
|  |                       |  |             | following 2 quarters.   |                  |
|  | _                     | ntary seclusion, and                     |             |   |                  |
|  | exploitation"         |  |             | As a means of quality assurar   | ice,             |
|  |                       |  |             | results of the audits and any   |                  |
|  | This citation relates | to Complaint IN00458662.                 |             | corrective actions taken shall  |                  |
|  |                       |  |             | reviewed by the Quality Assur   | I                |
|  | 3.1-27(b)             |  |             | Committee for a minimum of s  | six              |
|  |                       |  |             | (6) months, with frequency of   |                  |
|  |                       |  |             | monitoring increased or decre   | ased             |
|  |                       |  |             | on the basis of compliance.   |                  |
|  |                       |  |             |   |                  |
|  |                       |  |             | 5 – Corrective action complete  | ed by            |
|  |                       |  |             | 6/9/2025.   |                  |
|  |                       |  |             |   |                  |
| F 0607   | 483.12(b)(1)-(5)(ii   |  |             |   |                  |
| SS=E   | Develop/Impleme       | nt Abuse/Neglect Policies                |             |   |                  |
| Bldg. 00   |                       |  |             |   |                  |
|  |                       | view and interview, the facility         | F 0607      | F607  | 06/09/2025       |
|  | _                     | their facility abuse prevention          |             |   |                  |
|  | program policy who    | en staff members failed to               |             | It is the practice of this facility   | to               |
|  | report an incident o  | f staff to resident verbal               |             | thoroughly investigate allegati   | ons              |
|  | abuse, which delays   | ed the initiation of the facility        |             | of abuse, neglect, exploitation   | , or             |
|  | investigation and re  | porting to the appropriate               |             | mistreatment according to our   |                  |
|  | agencies, for 1 of 4  | residents reviewed for abuse.            |             | policies and procedures.  |                  |
|  | (QMA 1, Resident      | D, and LPN 2)                            |             |   |                  |
|  |                       |  |             | 1 – What corrective action will   | be               |
|  | Findings include:     |  |             | accomplished for those reside   | ents             |
|  |                       |  |             | found to have been affected b   | y the            |
|  | Review of a facility  | self-reportable incident report,         |             | deficient practice:   | •                |
|  | -                     | ated on 4/9/25 at approximately          |             | a Upon notification of allege   | ed               |
|  |                       | was overheard using                      |             | deficient investigation, the fac  |                  |
|  |                       | age in a disrespectful manner            |             | policy and procedures for   | <b>'</b>         |
|  |                       | incident was reported to the             |             | allegations of abuse were revi  | iewed            |
|  | State on 4/9/25 at 1  | •  |             | and updated.  |                  |
|  |                       |  |             | b Our checklist was update  | d to             |
|  | The clinical record   | for Resident D was reviewed              |             | be completed for investigation  |                  |
|  | 1110 011111001 100010 | 101 1100140111 10 1140 10 110 110 110 11 | 1           | T so completed for investigation  | .o.              |

FORM CMS-2567(02-99) Previous Versions Obsolete

on 5/27/25 at 11:40 a.m. Diagnoses included

Event ID:

300611

Facility ID: 000269

If continuation sheet

LPN #2, LPN #1, and C.N.A.

Page 4 of 9

| STATEMENT OF DEFICIENCIES |                       | X1) PROVIDER/SUPPLIER/CLIA       | (X2) MULTIPLE CONSTRUCTION     |        | ONSTRUCTION   | (X3) DATE SURVEY |            |
|---------------------------|-----------------------|----------------------------------|--------------------------------|--------|---|------------------|------------|
| AND PLAN OF CORRECTION    |                       | IDENTIFICATION NUMBER            | A. BUILDING <u>00</u>          |        | 00  | COMPLETED        |            |
| 155400                    |                       | B. WING 05/27/2025               |                                |        | 2025  |                  |            |
|                           |                       |                                  |                                | CTREET | ADDRESS, CITY, STATE, ZIP COD   |                  |            |
| NAME OF P                 | ROVIDER OR SUPPLIER   | L                                |                                |        |   |                  |            |
| CARRINI                   | AL CADE OTDATE        | 2150                             |                                |        | JACKSON ST  |                  |            |
| CARDINA                   | AL CARE STRATE        | 3IE2                             |                                | MUNCI  | E, IN 47303   |                  |            |
| (X4) ID                   | SUMMARY               | STATEMENT OF DEFICIENCIE         |                                | ID     | PROVIDER'S PLAN OF CORRECTION   |                  | (X5)       |
| PREFIX                    | (EACH DEFICIEN        | CY MUST BE PRECEDED BY FULL      |                                | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE               | COMPLETION |
| TAG                       | REGULATORY OR         | LSC IDENTIFYING INFORMATION      |                                | TAG    | DEFICIENCY)   |                  | DATE       |
|                           | schizophrenia, conv   | rulsions, morbid severe          |                                |        | #3 were in-serviced 5/27/2025   | 5                |            |
|                           | obesity with alveola  | ar hypoventilation, and          |                                |        | regarding the facility policy an  | d                |            |
|                           | hypertension.         |                                  |                                |        | procedures for allegations of   |                  |            |
|                           |                       |                                  |                                |        | abuse which includes the  |                  |            |
|                           | Review of a facility  | self-reportable incident report, |                                |        | immediate notification of   |                  |            |
|                           | dated 4/9/25, indica  | ted on 4/9/25 at approximately   |                                |        | Administrator and DON.  |                  |            |
|                           | 5:30 a.m., QMA 1 v    | was overheard using              |                                |        | d Q.M.A. #1 employment w  | as               |            |
|                           | inappropriate langu   | age in a disrespectful manner    |                                |        | terminated based on investiga   |                  |            |
|                           | to Resident D. The    | incident was reported to the     |                                |        |   |                  |            |
|                           | State on 4/9/25 at 1  | 0:39 a.m.                        |                                |        |   |                  |            |
|                           |                       |                                  |                                |        | 2 – How other residents havin   | g the            |            |
|                           | Review of a written   | statement by LPN 2, dated        |                                |        | potential to be affected by the   |                  |            |
|                           | 4/9/25, indicated sh  | e heard QMA 1 tell Resident D    |                                |        | same deficient practice will be   | ;                |            |
|                           | "You need to clean    | your f king room". Resident      | identified and what corrective |        |   |                  |            |
|                           | D said "What?" and    | was crying. QMA 1 left the       |                                |        | action(s) will be taken:  |                  |            |
|                           | room before LPN 2     | got to the resident's room.      |                                |        |   |                  |            |
|                           | QMA 1 told LPN 2      | "I'm done. He is a f king d -    |                                |        | a All residents have the  |                  |            |
|                           | -k". LPN 1 indicate   | ed she spent approximately       |                                |        | potential to be affected by the   |                  |            |
|                           | 20-30 minutes with    | the resident and tried to calm   |                                |        | alleged deficient practice.   |                  |            |
|                           | him down. CNA 3       | entered the resident's room and  |                                |        |   |                  |            |
|                           | stayed with him to l  | nelp calm him down.              |                                |        | 3 – What measures will be put   | t                |            |
|                           |                       |                                  |                                |        | into place and what systemic  |                  |            |
|                           | During an interview   | on 5/27/25 at 10:54 a.m., LPN    |                                |        | changes will be made to ensu  | re               |            |
|                           | 2 indicated on 4/9/2  | 5 at approximately 5:30 a.m.,    |                                |        | that the deficient practice does  | s not            |            |
|                           | she overheard QMA     | A 1 yelling and using            |                                |        | recur:  |                  |            |
|                           | inappropriate langu   | age at the resident. She         |                                |        | a An in-service was comple  | eted             |            |
|                           | entered the resident  | 's room and QMA 1 left. She      |                                |        | on 5/28/2025 by the Administr   | rator            |            |
|                           | indicated the reside  | nt was upset and crying. The     |                                |        | and Director of Nursing with  |                  |            |
|                           | resident told her QM  | MA 1 should not have spoken      |                                |        | management staff who can as   | ssist            |            |
|                           | to him like that. LP  | N 2 did not report this incident |                                |        | with an investigation including   | but              |            |
|                           | to anyone immediat    | tely. She indicated QMA 1 had    |                                |        | not limited to allegations of   |                  |            |
|                           | left the area and she | e felt the resident was safe.    |                                |        | abuse. This included a review   | v of             |            |
|                           | CNA 3 entered the     | room and stayed with the         |                                |        | the facility policy and procedu   | res              |            |
|                           | resident until they c | almed down.                      |                                |        | for allegations which included  |                  |            |
|                           |                       |                                  |                                |        | immediate notification of   |                  |            |
|                           | CNA 3 was not ava     | ilable for interview during the  |                                |        | Administrator and DON. The  |                  |            |
|                           | survey.               |                                  |                                |        | review of the checklist was als   | 30               |            |
|                           |                       |                                  |                                |        | reviewed with the Managemer   | nt               |            |
|                           | QMA 1's employme      | ent was terminated and not       |                                |        | Staff.  |                  |            |
|                           | available for intervi | ew during the survey.            |                                |        | b An in-service was comple  | eted             |            |

| STATEMENT OF DEFICIENCIES |                      | X1) PROVIDER/SUPPLIER/CLIA                           | (X2) MULTIPLE CONST                  |                                    | ONSTRUCTION   | (X3) DATE SURVEY |                    |
|---------------------------|----------------------|--|--------------------------------------|------------------------------------|---|------------------|--------------------|
| AND PLAN OF CORRECTION    |                      | IDENTIFICATION NUMBER                                | A. B                                 | UILDING                            | 00  | COMPLETED        |                    |
|                           |                      | 155400   | B. W                                 | ING                                |   | 05/27/           | 2025               |
|                           |                      |  | <u> </u>                             | STREET A                           | ADDRESS, CITY, STATE, ZIP COD   |                  |                    |
| NAME OF P                 | PROVIDER OR SUPPLIEF | 8  |                                      |                                    | JACKSON ST  |                  |                    |
| CARDINA                   | AL CARE STRATE       | GIES   |                                      |                                    | E, IN 47303   |                  |                    |
| (X4) ID                   | CIMMADN              | STATEMENT OF DEDICIENCIE                             | 1                                    | ID                                 |   |                  | (V5)               |
| PREFIX                    |                      | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL |                                      | PREFIX                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE                    |                  | (X5)<br>COMPLETION |
| TAG                       | ì ·                  | R LSC IDENTIFYING INFORMATION                        |                                      | TAG                                | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE               | DATE               |
| IAU                       | REGULATORT OF        | CESC IDENTIFITING INFORMATION                        | +                                    | IAU                                | on 5/28/2025 for nursing staff  | hv               | DATE               |
|                           | During an interview  | on 5/27/25 at 11:30 a.m.,                            |                                      |                                    | Administrator and DON in reg  | -                |                    |
|                           | _                    | d QMA 1 had yelled and                               |                                      |                                    | to the facility policy and  | aiu              |                    |
|                           |                      | use his floor was dirty. The                         |                                      |                                    |   |                  |                    |
|                           | incident made him    | _  |                                      |                                    | procedures for allegations of abuse which included immedia                            | ato              |                    |
|                           | incluent made min    | icei bad .   |                                      |                                    | notification of Administrator ar  |                  |                    |
|                           | During an interview  | on 5/27/25 at 11:54 a.m., the                        |                                      |                                    | DON.  | iu               |                    |
|                           | 1                    | she became aware of the                              |                                      |                                    | DON.  |                  |                    |
|                           |                      | with the resident. The resident                      |                                      |                                    | 4 – How the corrective action(  | c)               |                    |
|                           |                      | d hurt his feelings and made                         |                                      |                                    | will be monitored to ensure the   | ,                |                    |
|                           | him cry.             | a nare mo reeningo ana made                          |                                      |                                    | deficient practice will not recui   |                  |                    |
|                           | illin cry.           |  |                                      |                                    | i.e, what quality assurance   | ,                |                    |
|                           | During an interview  | on 5/27/25 at 12:34 p.m., the                        |                                      |                                    | program will be put into place:   | 2                |                    |
|                           | 1                    | arrived at the facility at around                    |                                      |                                    | 1   |                  |                    |
|                           |                      | y in question and was informed                       | The Administrator and/or Designee    |                                    |   |                  |                    |
|                           | · ·                  | Unit Manager 4 on 4/9/25 at                          | will conduct an audit of all         |                                    |   |                  |                    |
|                           | · ·                  | 0 a.m. She immediately informed                      |                                      | investigations for thoroughness of |   |                  |                    |
|                           |                      | nd initiated an investigation.                       |                                      |                                    | following the facility policy and   | l                |                    |
|                           |                      | s no longer employed at the                          | procedures, including but not        |                                    |   |                  |                    |
|                           |                      | able to be reached for interview                     |                                      |                                    | limited to allegations of abuse   |                  |                    |
|                           | during the survey.   | to be reached for interview                          | Dates and time of notifications will |                                    |   |                  |                    |
|                           | during the survey.   |  |                                      |                                    | be documented on the investigation as well. If  |                  |                    |
|                           | During an interview  | on 5/27/25 at 2:23 p.m., both                        |                                      |                                    | discrepancies are noted, then   |                  |                    |
|                           | 1                    | nd DON indicated LPN 2                               |                                      |                                    | immediate action will be taken  |                  |                    |
|                           | should have immed    |  |                                      |                                    | correct. This will be monitored   |                  |                    |
|                           |                      | I of the incident and QMA 1                          |                                      |                                    | times per week for 4 weeks, the   |                  |                    |
|                           |                      | ent home immediately.                                |                                      |                                    | 1 time per week for 4 weeks a   |                  |                    |
|                           | Should have been so  | and nome infinediately.                              |                                      |                                    | then monthly for the following  |                  |                    |
|                           | A current noticy de  | ated 2/1/2023, titled "Abuse                         |                                      |                                    | quarters.   | _                |                    |
|                           |                      | ovided by the Administrator                          |                                      |                                    | quarters.   |                  |                    |
|                           | _                    | a.m. The policy indicated the                        |                                      |                                    | As a means of quality assurar   | ice              |                    |
|                           | following:           | min The policy maleuted the                          |                                      |                                    | results of the audits and any   | ,                |                    |
|                           | _                    | ernal Reporting: a. Employees                        |                                      |                                    | corrective actions taken shall  | he               |                    |
|                           |                      | any "abuse" or suspicions of                         |                                      |                                    | reviewed by the Quality Assur   |                  |                    |
|                           |                      | y to the Administrator.                              |                                      |                                    | Committee for a minimum of s  |                  |                    |
|                           |                      | eport can make employee just                         |                                      |                                    | (6) months, with frequency of   | "'''             |                    |
|                           |                      | ne abuse in accordance with                          |                                      |                                    | monitoring increased or decre   | ased             |                    |
|                           | State Law"           | at accordance with                                   |                                      |                                    | on the basis of compliance.   | ascu             |                    |
|                           | Suite Daw            |  |                                      |                                    | on the basis of compliance.   |                  |                    |
|                           | Cross reference F60  | 00.  |                                      |                                    | 5 – Corrective action complete  | ed by            |                    |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

300611

Facility ID: 000269

If continuation sheet Page 6 of 9

|  | K MEDICARE & MEDIC     |  |                        |   | ONID NO. 0938-039       |  |
|--|------------------------|--|------------------------|---|-------------------------|--|
|  |                        | X1) PROVIDER/SUPPLIER/CLIA                                 | (X2) MULTIPLE C        | <b>f</b> '  | (X3) DATE SURVEY        |  |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155400 |                        | IDENTIFICATION NUMBER                                      | A. BUILDING<br>B. WING |   | COMPLETED<br>05/27/2025 |  |
|  |                        |  | _                      | JJ12112U2J  |                         |  |
| NAME OF I  | PROVIDER OR SUPPLIEF   | ₹  |                        | ADDRESS, CITY, STATE, ZIP COD   |                         |  |
| CARDIN   | AL CARE STRATE         | GIFS   |                        | E JACKSON ST<br>IE, IN 47303  |                         |  |
|  |                        |  |                        | 12, 11 17 000   | 1                       |  |
| (X4) ID  |                        | STATEMENT OF DEFICIENCIE                                   | ID                     | PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE                         | (X5)                    |  |
| PREFIX<br>TAG  | ``                     | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PREFIX                 | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | COMPLETION DATE         |  |
| TAG  | REGULATORY OF          | CLSC IDENTIFFING INFORMATION                               | TAG                    | 6/9/2025.   | DATE                    |  |
|  | This citation relates  | s to Complaint IN00458662.                                 |                        | 0/3/2020.   |                         |  |
|  | 2120()                 |  |                        |   |                         |  |
|  | 3.1-28(c)              |  |                        |   |                         |  |
| F 0610   | 483.12(c)(2)-(4)       |  |                        |   |                         |  |
| SS=D   |                        | nt/Correct Alleged Violation                               |                        |   |                         |  |
| Bldg. 00   | Based on interview     | and record review, the facility                            | F 0610                 | F610  | 06/09/2025              |  |
|  |                        | t their policy regarding abuse                             | 1 0010                 | 1010  | 00/09/2023              |  |
|  | _                      | they failed to provide                                     |                        | It is the practice of this facility to  |                         |  |
|  | _                      | chosocial harm for vulnerable,                             |                        | thoroughly investigate allegations  |                         |  |
|  | cognitively impaire    | ed residents following an                                  |                        | of abuse, neglect, exploitation, or   |                         |  |
|  | allegation of staff to | o resident verbal abuse. This                              |                        | mistreatment according to our   |                         |  |
|  | deficient practice ha  | ad the potential to effect 3 of                            |                        | policies and procedures and   |                         |  |
|  |                        | in on the unit where the abuse                             |                        | document accordingly after  |                         |  |
|  | was alleged. Reside    | ents E, F, and G)  |                        | assessments of cognitively  |                         |  |
|  |                        |  |                        | impaired residents.   |                         |  |
|  | Findings include:      |  |                        |   |                         |  |
|  |                        | 10   |                        | 1 – What corrective action will be  |                         |  |
|  |                        | self-reportable incident report,                           |                        | accomplished for those residents  |                         |  |
|  |                        | ated on 4/9/25 at approximately                            |                        | found to have been affected by the  | e                       |  |
|  |                        | was overheard using lage in a disrespectful manner         |                        | deficient practice:   |                         |  |
|  |                        | incident was reported to the                               |                        | a Upon notification of alleged deficient investigation, the facility                    |                         |  |
|  | State on 4/9/25 at 1   | _  |                        | policy and procedures for   |                         |  |
|  | State on 119123 at 1   | 0.57 4.111.  |                        | allegations of abuse were reviewe   | <sub>rd</sub>           |  |
|  | The facility's invest  | tigation of a verbal abuse                                 |                        | and updated.  |                         |  |
|  |                        | ewed on 5/27/25 at 9:57 a.m.                               |                        | b— Social Services was  |                         |  |
|  | 1 -                    | ncluded, staff re-education,                               |                        | in-serviced 5/28/2025 on the  |                         |  |
|  | _                      | erviews of cognitively intact                              |                        | completion of an assessment of  |                         |  |
|  | residents, and skin    | assessments. The   |                        | psychosocial status for   |                         |  |
|  | investigation lacked   | d psychosocial   |                        | non-interview able residents durin  | g                       |  |
|  | assessments/evalua     | tions of vulnerable or                                     |                        | the investigation process for   |                         |  |
|  | non-verbal resident    | s.   |                        | allegations of abuse  |                         |  |
|  | 1. The clinical reco   | rd for Resident E was reviewed                             |                        | 2 – How other residents having th   | e                       |  |
|  | on 5/27/25 at 10:07    | a.m. Diagnoses included                                    |                        | potential to be affected by the   |                         |  |
|  |                        | and dementia. The clinical                                 |                        | same deficient practice will be   |                         |  |
|  |                        | sment of psychosocial status                               |                        | identified and what corrective  |                         |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400 |  | A. B   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                                    |   | (X3) DATE SURVEY COMPLETED 05/27/2025 |            |
|---|--|--|--|------------------------------------|---|---------------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER  |  |  | -  |                                    | ADDRESS, CITY, STATE, ZIP COD                                       |                                       |            |
| CARDIN  | AL CARE STRATE   | GIES   |  |                                    | JACKSON ST<br>IE, IN 47303  |                                       |            |
| (X4) ID   | SUMMARY  | STATEMENT OF DEFICIENCIE                             |  | ID                                 | PROVIDER'S PLAN OF CORRECTION                                       |                                       | (X5)       |
| PREFIX  | `  | ICY MUST BE PRECEDED BY FULL                         |  | PREFIX                             | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE.                                   | COMPLETION |
| TAG   |  | R LSC IDENTIFYING INFORMATION                        |  | TAG                                | DEFICIENCY)   |                                       | DATE       |
|   | during the time of t<br>investigation begin  |  |  |                                    | action(s) will be taken:  |                                       |            |
|   | investigation begin  | ming on 4/9/23.                                      |  |                                    | a All residents have the potential to be affected by the            |                                       |            |
|   | A current quarterly  | Minimum Data Set (MDS)                               |  |                                    | alleged deficient practice.   |                                       |            |
|   |  | 3/25/25, indicated the resident                      |  |                                    | aneged denotern produce.  |                                       |            |
|   | was severely cogni   | tively impaired.                                     |  |                                    | 3 – What measures will be pu  | t                                     |            |
|   |  |  |  |                                    | into place and what systemic  |                                       |            |
|   | The resident was no  | ot interviewable during the                          |  |                                    | changes will be made to ensu  |                                       |            |
|   | survey.  |  |  |                                    | that the deficient practice doe                                     | s not                                 |            |
|   | 0.751 1: : 1   | 16 D :1 (F : 1                                       |  |                                    | recur:  |                                       |            |
|   |  | rd for Resident F was reviewed                       |  |                                    | a An in-service was comple  |                                       |            |
|   |  | a.m. Diagnoses included                              |  |                                    | on 5/28/2025 by the Administration with management staff who care   |                                       |            |
|   | depression, anxiety and dementia. The clinical record lacked assessment of psychosocial status |  |  |                                    | assist with an investigation  | all                                   |            |
|   | during the time of the facility's abuse  |  |  |                                    | including but not limited to  |                                       |            |
|   | investigation begin  |  |  |                                    | allegations of abuse. This  |                                       |            |
|   |  |  |  |                                    | included the review of the faci                                     | lity                                  |            |
|   |  | nt change Minimum Data Set                           |  |                                    | policy and procedures for   |                                       |            |
|   |  | dated 4/9/25, indicated the                          |  |                                    | allegations of abuse which  |                                       |            |
|   | resident was not int   | erviewable.  |  |                                    | included immediate notification of                                  |                                       |            |
|   |  |  |  |                                    | Administrator and DON. The  |                                       |            |
|   |  | ot interviewable during the                          |  |                                    | review of the checklist was also                                    |                                       |            |
|   | survey.  |  |  |                                    | reviewed with the Manageme Staff.                                   |                                       |            |
|   | 3. The clinical reco   | rd for Resident G was reviewed                       |  |                                    | Stan.   |                                       |            |
|   |  | a.m. Diagnoses included                              |  |                                    | 4 – How the corrective action(                                      | s)                                    |            |
|   |  | piratory failure, and diabetes                       |  | will be monitored to ensure the    |   | ,                                     |            |
|   | type 2. The clinical   | record lacked assessment of                          |  | deficient practice will not recur, |   | r,                                    |            |
|   |  | during the time of the                               |  |                                    | i.e, what quality assurance   |                                       |            |
|   | facility's abuse inve  | estigation beginning on 4/9/25.                      |  | program will be put into place:a   |   |                                       |            |
|   |  | N  |  | The Administrator and/or Designee  |   | ignee                                 |            |
|   |  | Minimum Data Set (MDS)                               |  |                                    | will conduct an audit of all  |                                       |            |
|   |  | 4/3/25, indicated the resident ble due to delusions. |  |                                    | investigations for thoroughnes following the facility policy and    |                                       |            |
|   | was not interviewal  | sie due to defusions.                                |  |                                    | procedures, including but not                                       | 4                                     |            |
|   | The resident was no  | ot interviewable during the                          |  |                                    | limited to allegations of abuse                                     |                                       |            |
|   | survey.  |  |  |                                    | Documented assessments wi   |                                       |            |
|   |  |  |  |                                    | audited on the investigations                                       |                                       |            |
|   | During an interview  | v on 5/27/25 at 2:23 p.m., the                       |  |                                    | well. If discrepancies are note                                     |                                       |            |
|   | Administrator and  | Administrator and DON indicated the facility         |  |                                    | then immediate action will be                                       |                                       |            |

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Event ID:

300611

Facility ID: 000269

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                       | X2) MULTIPLE CONSTRUCTION       |                                  |                                   | (X3) DATE SURVEY   |           |            |
|--|-----------------------|---------------------------------|----------------------------------|-----------------------------------|--|-----------|------------|
| l  |                       |                                 | A. BUILDING 00                   |                                   |  | COMPLETED |            |
|  |                       | B. W                            |                                  |                                   | 05/27/2025   |           |            |
|  |                       | 1.55.1.5                        |                                  |                                   |  | 33,217    |            |
| NAME OF P  | ROVIDER OR SUPPLIER   | 3                               |                                  |                                   | ADDRESS, CITY, STATE, ZIP COD  |           |            |
| 0.4.55   |                       |                                 |                                  |                                   | JACKSON ST   |           |            |
| CARDINA  | AL CARE STRATE        | GIES                            |                                  | MUNCI                             | E, IN 47303  |           |            |
| (X4) ID  | SUMMARY               | STATEMENT OF DEFICIENCIE        |                                  | ID                                | PROVIDER'S PLAN OF CORRECTION  |           | (X5)       |
| PREFIX   | (EACH DEFICIEN        | ICY MUST BE PRECEDED BY FULL    |                                  | PREFIX                            | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATF       | COMPLETION |
| TAG  | REGULATORY OF         | R LSC IDENTIFYING INFORMATION   |                                  | TAG                               | DEFICIENCY)  |           | DATE       |
|  | should have but fai   | led to provide psychosocial     |                                  |                                   | taken to correct. This will be   |           |            |
|  | assessments for vul   | nerable residents as part of    |                                  |                                   | monitored 2 times per week for   | or 4      |            |
|  | the investigation.    |                                 |                                  |                                   | weeks, then 1 time per week  | for 4     |            |
|  |                       |                                 |                                  |                                   | weeks and then monthly for th  | ne        |            |
|  |                       | ated 2/1/2023, titled "Abuse    |                                  |                                   | following 2 quarters.  |           |            |
|  |                       | ovided by the Administrator     |                                  |                                   |  |           |            |
|  |                       | a.m. The policy indicated the   | As a means of quality assurance, |                                   |  | nce,      |            |
|  | following:            |                                 |                                  |                                   | results of the audits and any  |           |            |
|  |                       | n of abuse: When an incident    |                                  |                                   | corrective actions taken shall be                                      |           |            |
|  | •                     | nt of abuse is reported, the    |                                  | reviewed by the Quality Assurance |  |           |            |
|  |                       | esignee will investigate the    |                                  | Committee for a minimum of six    |  |           |            |
|  |                       | ssistance of appropriate        |                                  | (6) months, with frequency of     |  |           |            |
|  | •                     | estigation will include:        |                                  | monitoring increased or decreased |  |           |            |
|  | ii. Residents' sta    |                                 |                                  |                                   | on the basis of compliance.  |           |            |
|  |                       | esidents, cognitively impaired  |                                  |                                   |  |           |            |
|  |                       | fuse to be interviewed, attempt |                                  |                                   | 5 – Corrective action complete   | ed by     |            |
|  |                       | nts first. If unable, observe   |                                  |                                   | 6/9/2025.  |           |            |
|  |                       | an evaluation of resident       |                                  |                                   |  |           |            |
|  |                       | d response to interaction, and  |                                  |                                   |  |           |            |
|  | document findings.    | "                               |                                  |                                   |  |           |            |
|  |                       |                                 |                                  |                                   |  |           |            |
|  | Cross reference F60   | JU.                             |                                  |                                   |  |           |            |
|  | This citation relates | s to Complaint IN00458662.      |                                  |                                   |  |           |            |
|  | This chanon relates   | 5 to Complaint 11100+30002.     |                                  |                                   |  |           |            |
|  | 3.1-28(d)             |                                 |                                  |                                   |  |           |            |
|  | 20(4)                 |                                 |                                  |                                   |  |           |            |
|  |                       |                                 |                                  |                                   | •  |           | •          |

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