STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00459988, IN00458991, and IN00458662. Complaint IN00459988 - No deficiencies related to the allegations are cited. Complaint IN00458991 - No deficiencies related to the allegations are cited. Complaint IN00458662 - Federal/State deficiencies related to the allegations are cited at F600, F607, and F610. Survey dates: May 23 and 27, 2025 Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 1 Medicaid: 65 Other: 8 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 29, 2025.	F 0000	**June 13, 2025** **Ms. Suzanne Williams** **Director of Long Term Care** **2 North Meridian St.** **Indianapolis, IN 46204** **Re: Survey Event ID 3O0611** **Dear Ms. Williams:** **Please find attached my Plan of Correction for deficiencies cited during a complaint survey. I am respectfully requesting paper compliance.** **If you have any questions, please feel free to contact me.** **Sincerely,** **Shannon Harris** **Administrator**	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Harris	Administrator	06/25/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on interviews and record review, the facility failed to protect a resident's right to be free from verbal abuse by staff for 1 of 3 residents reviewed for abuse. (QMA 1, Resident D) Findings include: The clinical record for Resident D was reviewed on 5/27/25 at 11:40 a.m. Diagnoses included schizophrenia, convulsions, morbid severe obesity with alveolar hypoventilation, and hypertension. Review of a facility self-reportable incident report, dated 4/9/25, indicated on 4/9/25 at approximately 5:30 a.m., QMA 1 was overheard using inappropriate language in a disrespectful manner to Resident D. The incident was reported to the State on 4/9/25 at 10:39 a.m. Review of a written statement by LPN 2, dated 4/9/25, indicated she heard QMA 1 tell Resident D "You need to clean your f - - king room". Resident D said "What?" and was crying. QMA 1 left the room before LPN 2 got to the resident's room. QMA 1 told LPN 2 "I'm done. He is a f - - king d - -k". LPN 1 indicated she spent approximately 20-30 minutes with the resident and tried to calm him down. CNA 3 entered the resident's room and stayed with him to help calm him down. During an interview on 5/27/25 at 10:54 a.m. , LPN 2 indicated on 4/9/25 at approximately 5:30 a.m., she overheard QMA 1 yelling and using inappropriate language at the resident. She entered the resident's room and QMA 1 left. She indicated the resident was upset and crying. The resident told her QMA 1 should not have spoken to him like that. LPN 2 did not report this incident to anyone immediately. She indicated QMA 1 had	F 0600	F600 It is the practice of this facility to protect our residents from abuse and neglect. 1 – What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Upon notification of alleged deficient investigation, the facility policy and procedures for allegations of abuse were reviewed and updated. b A checklist was updated to be completed for investigations. c LPN #2, LPN #1, and C.N.A. #3 were in-serviced 5/27/25 regarding the facility policy and procedures for allegations of abuse which includes the immediate notification of Administrator and DON. d Q.M.A. #1 employment was terminated based on investigation. 2 – How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a All residents have the potential to be affected by the alleged deficient practice. 3 – What measures will be put into place and what systemic changes will be made to ensure	06/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	left the area and she felt the resident was safe. CNA 3 entered the room and stayed with the resident until they calmed down. CNA 3 was not available for interview during the survey. QMA 1's employment was terminated and not available for interview during the survey. During an interview on 5/27/25 at 11:30 a.m., Resident D indicated QMA 1 had yelled and cursed at him because his floor was dirty. The incident made him feel "bad". During an interview on 5/27/25 at 11:54 a.m., the SSD indicated after she became aware of the incident, she spoke with the resident. The resident told her QMA 1 had hurt his feelings and made him cry. During an interview on 5/27/25 at 12:34 p.m., the DON indicated she arrived at the facility at around 8:00 a.m. on the day in question and was informed of the incident by Unit Manager 4 on 4/9/25 at approximately 10:00 a.m. She immediately informed the Administrator and initiated an investigation. Unit Manager 4 was no longer employed at the facility and was unable to be reached for interview during the survey. During an interview on 5/27/25 at 2:23 p.m., both the Administrator and DON indicated LPN 2 should have immediately informed the Administrator/DON of the incident and QMA 1 should have been sent home immediately. A current policy, dated 2/1/2023, titled "Abuse Prevention and Prohibition Policy" was provided by the Administrator on 5/27/25 at 11:40 a.m. The		that the deficient practice does not recur: a An in-service was completed on 5/28/25 by the Administrator and Director of Nursing and Assistant Director of Nursing with management staff who can assist with an investigation including but not limited to allegations of abuse. This included the review of the facility policy and procedures for allegations of abuse which included immediate notification of Administrator and DON. The review of the checklist was also reviewed with the Management Staff. b An in-service was completed on 5/28/2025 for nursing staff by Administrator and DON in regard to the facility policy and procedures for allegations of abuse which included immediate notification of Administrator and DON. 4 – How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place:a The Administrator and/or Designee will conduct an audit of all investigations for thoroughness of following the facility policy and procedures, including but not limited to allegations of abuse. Dates and time of notifications will be documented on the investigation as well. This will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	policy indicated the following: "Purpose: To ensure the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and exploitation. ...." This citation relates to Complaint IN00458662. 3.1-27(b)		monitored 2 times per week for 4 weeks, then 1 time per week for 4 weeks and then monthly for the following 2 quarters. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 6/9/2025.	
F 0607 SS=E Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies Based on record review and interview, the facility failed to implement their facility abuse prevention program policy when staff members failed to report an incident of staff to resident verbal abuse, which delayed the initiation of the facility investigation and reporting to the appropriate agencies, for 1 of 4 residents reviewed for abuse. (QMA 1, Resident D, and LPN 2) Findings include: Review of a facility self-reportable incident report, dated 4/9/25, indicated on 4/9/25 at approximately 5:30 a.m., QMA 1 was overheard using inappropriate language in a disrespectful manner to Resident D. The incident was reported to the State on 4/9/25 at 10:39 a.m. The clinical record for Resident D was reviewed on 5/27/25 at 11:40 a.m. Diagnoses included	F 0607	F607 It is the practice of this facility to thoroughly investigate allegations of abuse, neglect, exploitation, or mistreatment according to our policies and procedures. 1 – What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Upon notification of alleged deficient investigation, the facility policy and procedures for allegations of abuse were reviewed and updated. b Our checklist was updated to be completed for investigations. c LPN #2, LPN #1, and C.N.A.	06/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	schizophrenia, convulsions, morbid severe obesity with alveolar hypoventilation, and hypertension. Review of a facility self-reportable incident report, dated 4/9/25, indicated on 4/9/25 at approximately 5:30 a.m., QMA 1 was overheard using inappropriate language in a disrespectful manner to Resident D. The incident was reported to the State on 4/9/25 at 10:39 a.m. Review of a written statement by LPN 2, dated 4/9/25, indicated she heard QMA 1 tell Resident D "You need to clean your f - - king room". Resident D said "What?" and was crying. QMA 1 left the room before LPN 2 got to the resident's room. QMA 1 told LPN 2 "I'm done. He is a f - - king d - -k". LPN 1 indicated she spent approximately 20-30 minutes with the resident and tried to calm him down. CNA 3 entered the resident's room and stayed with him to help calm him down. During an interview on 5/27/25 at 10:54 a.m. , LPN 2 indicated on 4/9/25 at approximately 5:30 a.m., she overheard QMA 1 yelling and using inappropriate language at the resident. She entered the resident's room and QMA 1 left. She indicated the resident was upset and crying. The resident told her QMA 1 should not have spoken to him like that. LPN 2 did not report this incident to anyone immediately. She indicated QMA 1 had left the area and she felt the resident was safe. CNA 3 entered the room and stayed with the resident until they calmed down. CNA 3 was not available for interview during the survey. QMA 1's employment was terminated and not available for interview during the survey.		#3 were in-serviced 5/27/2025 regarding the facility policy and procedures for allegations of abuse which includes the immediate notification of Administrator and DON. d Q.M.A. #1 employment was terminated based on investigation. 2 – How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a All residents have the potential to be affected by the alleged deficient practice. 3 – What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: a An in-service was completed on 5/28/2025 by the Administrator and Director of Nursing with management staff who can assist with an investigation including but not limited to allegations of abuse. This included a review of the facility policy and procedures for allegations which included immediate notification of Administrator and DON. The review of the checklist was also reviewed with the Management Staff. b An in-service was completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 5/27/25 at 11:30 a.m., Resident D indicated QMA 1 had yelled and cursed at him because his floor was dirty. The incident made him feel "bad". During an interview on 5/27/25 at 11:54 a.m., the SSD indicated after she became aware of the incident, she spoke with the resident. The resident told her QMA 1 had hurt his feelings and made him cry. During an interview on 5/27/25 at 12:34 p.m., the DON indicated she arrived at the facility at around 8:00 a.m. on the day in question and was informed of the incident by Unit Manager 4 on 4/9/25 at approximately 10:00 a.m. She immediately informed the Administrator and initiated an investigation. Unit Manager 4 was no longer employed at the facility and was unable to be reached for interview during the survey. During an interview on 5/27/25 at 2:23 p.m., both the Administrator and DON indicated LPN 2 should have immediately informed the Administrator/DON of the incident and QMA 1 should have been sent home immediately. A current policy, dated 2/1/2023, titled "Abuse Prohibition" was provided by the Administrator on 5/27/25 at 11:40 a.m. The policy indicated the following: " .... Procedure: Internal Reporting: a. Employees must always report any "abuse" or suspicions of "abuse" immediately to the Administrator. **Note: failure to report can make employee just as responsible for the abuse in accordance with State Law. ...." Cross reference F600.		on 5/28/2025 for nursing staff by Administrator and DON in regard to the facility policy and procedures for allegations of abuse which included immediate notification of Administrator and DON. 4 – How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place:~~a~~ The Administrator and/or Designee will conduct an audit of all investigations for thoroughness of following the facility policy and procedures, including but not limited to allegations of abuse. Dates and time of notifications will be documented on the investigation as well. If discrepancies are noted, then immediate action will be taken to correct. This will be monitored 2 times per week for 4 weeks, then 1 time per week for 4 weeks and then monthly for the following 2 quarters. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This citation relates to Complaint IN00458662. 3.1-28(c)		6/9/2025.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview and record review, the facility failed to implement their policy regarding abuse investigation when they failed to provide assessment for psychosocial harm for vulnerable, cognitively impaired residents following an allegation of staff to resident verbal abuse. This deficient practice had the potential to effect 3 of 17 residents living in on the unit where the abuse was alleged. Residents E, F, and G) Findings include: Review of a facility self-reportable incident report, dated 4/9/25, indicated on 4/9/25 at approximately 5:30 a.m., QMA 1 was overheard using inappropriate language in a disrespectful manner to Resident D. The incident was reported to the State on 4/9/25 at 10:39 a.m. The facility's investigation of a verbal abuse allegation was reviewed on 5/27/25 at 9:57 a.m. The investigation included, staff re-education, staff interviews, interviews of cognitively intact residents, and skin assessments. The investigation lacked psychosocial assessments/evaluations of vulnerable or non-verbal residents. 1. The clinical record for Resident E was reviewed on 5/27/25 at 10:07 a.m. Diagnoses included anxiety, depression and dementia. The clinical record lacked assessment of psychosocial status	F 0610	F610 It is the practice of this facility to thoroughly investigate allegations of abuse, neglect, exploitation, or mistreatment according to our policies and procedures and document accordingly after assessments of cognitively impaired residents. 1 – What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Upon notification of alleged deficient investigation, the facility policy and procedures for allegations of abuse were reviewed and updated. ~~b~~ Social Services was in-serviced 5/28/2025 on the completion of an assessment of psychosocial status for non-interview able residents during the investigation process for allegations of abuse. - 2 – How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	06/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	during the time of the facility's abuse investigation beginning on 4/9/25. A current quarterly Minimum Data Set (MDS) assessment, dated 3/25/25, indicated the resident was severely cognitively impaired. The resident was not interviewable during the survey. 2. The clinical record for Resident F was reviewed on 5/27/25 at 10:11 a.m. Diagnoses included depression, anxiety and dementia. The clinical record lacked assessment of psychosocial status during the time of the facility's abuse investigation beginning on 4/9/25. A current significant change Minimum Data Set (MDS) assessment, dated 4/9/25, indicated the resident was not interviewable. The resident was not interviewable during the survey. 3. The clinical record for Resident G was reviewed on 5/27/25 at 10:17 a.m. Diagnoses included Schizophrenia, respiratory failure, and diabetes type 2. The clinical record lacked assessment of psychosocial status during the time of the facility's abuse investigation beginning on 4/9/25. A current quarterly Minimum Data Set (MDS) assessment, dated 34/3/25, indicated the resident was not interviewable due to delusions. The resident was not interviewable during the survey. During an interview on 5/27/25 at 2:23 p.m., the Administrator and DON indicated the facility		action(s) will be taken: a All residents have the potential to be affected by the alleged deficient practice. 3 – What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: a An in-service was completed on 5/28/2025 by the Administrator with management staff who can assist with an investigation including but not limited to allegations of abuse. This included the review of the facility policy and procedures for allegations of abuse which included immediate notification of Administrator and DON. The review of the checklist was also reviewed with the Management Staff. 4 – How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place:a The Administrator and/or Designee will conduct an audit of all investigations for thoroughness of following the facility policy and procedures, including but not limited to allegations of abuse. Documented assessments will be audited on the investigations as well. If discrepancies are noted, then immediate action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should have but failed to provide psychosocial assessments for vulnerable residents as part of the investigation. A current policy, dated 2/1/2023, titled "Abuse Prohibition" was provided by the Administrator on 5/27/25 at 11:40 a.m. The policy indicated the following: " ,,,, a. Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: .... ii. Residents' statements a. For non-verbal residents, cognitively impaired or residents who refuse to be interviewed, attempt to interview residents first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings. ...." Cross reference F600. This citation relates to Complaint IN00458662. 3.1-28(d)		taken to correct. This will be monitored 2 times per week for 4 weeks, then 1 time per week for 4 weeks and then monthly for the following 2 quarters. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 6/9/2025.	