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	09/20/2024

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 IN00442724, IN00442377, IN00441739 and IN00440479. Complaint IN00442724 - No deficiencies related to the allegations are cited. Complaint IN00442377 - No deficiencies related to the allegations are cited. Complaint IN00441739 - No deficiencies related to the allegations are cited. Complaint IN00440479 - Federal/State deficiencies related to the allegations are cited at F610. Survey dates: September 19 and 20, 2024 Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 2 Medicaid: 67 Other: 7 Total: 76 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 30, 2024.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 10/03/2024 to the state findings of the recent complaint investigation. We are requesting paper compliance. October 9, 2024 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID 3PJ711 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during this Complaint Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Harris		10/10/2024

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.

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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 thoroughly investigate the an allegation of physical abuse of a cognitively impaired resident by a staff member for 1 of 5 residents reviewed for abuse. (CNA 1 and Resident F) Findings include: Review of a facility self reportable, dated 8/6/24 at 6:49 p.m., was completed on 9/19/24 at 1:33 p.m. The report indicated on 8/6/24, CNA 1 allegedly abused Resident F. The follow up for the investigation indicated staff who witnessed the incident were interviewed. The facility investigation lacked interviews of other staff members and residents to determine if there had been any other concerns with abuse. Resident F's clinical record was reviewed on 9/20/24 at 12:50 p.m. Diagnoses included Alzheimer's Disease, pulmonary fibrosis, rheumatoid arthritis, stage 3 chronic kidney disease, restless and agitation, muscle weakness and dementia with behavioral disturbances. An annual Minimum Data Set (MDS) assessment, dated 7/25/24, indicated the resident was severely cognitively impaired.	F 0610	Shannon Harris Administrator PROPOSED PLAN OF CORRECTION F610 It is the practice of this facility to thoroughly investigate allegations of abuse, neglect, exploitation, or mistreatment. 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 developed to be completed for investigations. 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	10/03/2024

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	An 8/6/24 written statement, by CNA 2 indicated Resident F was walking in the hallway. CNA 1 was also going down the hallway with a linen cart. CNA 1 grabbed the resident by the arm and attempted to pull the resident away. During an interview, on 9/20/24 at 2:10 p.m., Resident F was unable to answer screening questions accurately. During an interview on 9/19/24 at 2:03 p.m., the Administrator indicated the facility's investigation did not include interview or assessment of other residents. A current policy, dated 2/1/23, titled " Abuse Prevention And Prohibition Policy" was provided by the Administrator on 9/20/24 at 4:00 p.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 .... a. For non-verbal residents, cognitively impaired residents 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. ...." This citation relates to complaint IN00440479. 3.1-28(d)		alleged deficient practice. b There have been no new investigations initiated at this time. 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 9/26/2024 by the Administrator and Director of Nursing with management staff who can assist with an investigation including but not limited to allegations of abuse. 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. This will be an ongoing audit. 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.	

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			5 – Corrective action completed by 10/3/2024.	