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	10/23/2023

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 IN00419554 and IN00419944. Complaint IN00419554 - No deficiencies related to the allegations are cited. Complaint IN00419944 - Federal/state deficiencies related to the allegations are cited at F580. Survey dates: October 20 and 23, 2023. Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 3 Medicaid: 54 Other: 2 Total: 59 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 26, 2023.	F 0000	November 9, 2023 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID 53W611 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, Karsen Rauch, HFA Administrator Cardinal Care Strategies	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Karsen Rauch | HFA - Administrator | 11/15/2023

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	when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical			

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	configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure a resident's physician was notified for a resident who was sent to the hospital for 1 of 3 residents reviewed for hospital transfers (Resident C) and failed to notify residents' emergency contacts when the resident was sent to the hospital for 2 of 3 residents reviewed for emergency contact notification (Resident C and Resident B). Findings include: 1. Resident C's clinical record was reviewed on 10/20/23 at 11:20 a.m. Diagnoses included essential (primary) hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, presence of cardiac pacemaker, diabetes mellitus due to underlying condition with diabetic autonomic (poly) neuropathy and unspecified systolic (congestive) heart failure. A quarterly Minimum Data Set (MDS) assessment, dated 8/2/23, indicated he was cognitively intact. He was discharged to the hospital on 10/9/2023. His resident profile indicated a family member as the emergency contact. The clinical record lacked indication of the reason he was transferred to the hospital for emergency treatment. The clinical record lacked indication of	F 0580	PROPOSED PLAN OF CORRECTION F580 1 – Upon notification of deficiency, all nurses were in-serviced on the policy “Transfer or Discharge, Emergency.” The emphasis of this in-service is on proper notification of the emergency contact and physician/medical provider in the event that a resident is sent to the hospital. Which is a part of the policy. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator will communicate the importance of following the appropriate procedure outlined in the Transfer or Discharge policy. This in-service/education will be communicated to all nurses. The Administrator will outline the importance of notifying an emergency contact (even when the patient is their own responsible party) as well as the physician/medical provider. 4 – The Administrator will conduct	11/09/2023

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	notification of both the resident's physician and his emergency contact. A review of the history and physical note from the hospital, dated 10/9/23, indicated Resident C was unable to provide a list of his current medications. They had attempted to contact the facility for a list of medications, but were unable to reach anyone. 2. Resident B's clinical record was reviewed on 10/20/23 at 10:43 a.m. Diagnoses included chronic obstructive pulmonary disease, essential (primary) hypertension, type 2 diabetes mellitus with hyperglycemia and acute respiratory failure with hypoxia. A quarterly MDS assessment, dated 7/20/23, indicated she was cognitively intact. She was discharged to the hospital on 10/8/23. Her resident profile indicated a friend as the emergency contact. A nurse note, dated 10/8/23 at 6:30 p.m., indicated Resident B was incoherent and pulled at her oxygen tubing. She had low output and was diaphoretic. She had a fever and her blood sugar was 96. A blood pressure was unable to be obtained. She was screaming in pain and not responding appropriately when asked questions. She had sediment and a dark urine output. She refused to eat or drink. The nurse practitioner was notified, and a new order was received to send her to the emergency room for evaluation and treatment. The clinical record lacked notification to her emergency contact.		an audit for each emergency discharge and make sure notification of family member/emergency contact/guardian and physician/medical provider was completed. The Administrator will also make sure that documentation has been made in the residents' chart about notification. The administrator will continue this for 4 weeks or until compliance is maintained. As a means of quality assurance, results of the reviews 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 based on compliance. 5 – Corrective action completed by 11/15/2023	

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	During an interview with Resident C's emergency contact, on 10/23/23 at 4:06 p.m., she indicated she was not aware Resident C was transferred to the hospital until the hospital notified her that she was being admitted. She was not aware Resident C was having any problems and she had been at the facility four to five days prior to her going to the hospital. During an interview with the Unit Manger, on 10/23/23 at 1:16 p.m., she indicated Resident B was sent to the hospital on 10/9/23. Normally, she would get an order from the nurse practitioner to send a resident to the hospital. She would then call report to the hospital, get the paperwork ready, notify the emergency contact, and document it all in the nurses notes. She didn't know who sent Resident C to the hospital, but the DON talked about doing it. He was not wanting to get out of bed and the CNAs said he was slouching. They thought he may had aspirated, and they had downgraded his diet that morning for breakfast. During an interview with the DON, on 10/23/23 at 1:38 p.m., she indicated it was a collaborative decision of the management team to send Resident B out to the hospital. She couldn't remember who sent him to the hospital, but thought it was probably her. She would normally print a face sheet and paperwork, depending on the incident. They notified the doctor through a group chat on their cell phones. During an interview with LPN 12, on 10/23/23 at 2:26 p.m., she indicated the Unit Manager and the DON felt Resident C was showing signs of decline and opted to send him to the hospital. The Unit Manager and the DON handled him being sent to			

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	the hospital, so she assumed they made the notifications as well. During an interview with the Administrator, on 10/23/23 at 4:35 p.m., she indicated they did not have a specific policy for emergency contact notification when a resident was sent to the hospital. A current facility policy, dated 1/2023, titled "Resident Discharge," provided by the Administrator, on 10/23/23 at 3:06 p.m., indicated the following: "...Procedure: 1. Obtain an order from doctor or nurse practitioner to discharge resident. 2. Document reason for discharge. 3... verify the following forms and information are sent with resident or representative...d. Medication Administration Record..." This citation relates to Complaint IN00419944. 3.1-5(a)(2) 3.1-5(a)(4)			