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	03/21/2025

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 IN00450628, IN00450867, IN00454358, and IN00454626. Complaint IN00450628 - No deficiencies related to the allegations are cited. Complaint IN00450867 - No deficiencies related to the allegations are cited. Complaint IN00454358 - No deficiencies related to the allegations are cited. Complaint IN00454626 - Federal/state deficiencies related to the allegations are cited at F880. Unrelated deficiencies are cited at F695. Survey dates: March 20 & 21, 2025 Facility number: 0000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 4 Medicaid: 65 Other: 5 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	April 10, 2025 Ms. Suzanne Williams Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID **9WKQ11** 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Harris		04/11/2025

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	03/21/2025

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
	Quality review completed March 31, 2025.			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation and interview, the facility failed to provide and maintain dated storage bags for oxygen administration equipment to be stored in a clean manner for 3 of 3 residents observed for oxygen administration. (Residents J, K, & L) Findings include: During an initial observation on 3/20/25 at 10:16 a.m., a wheelchair was observed outside of Resident K's room with the nasal cannula attached to a portable oxygen tank. The cannula was observed draped over the back of the wheelchair, with the cannula laying in the seat of the chair. There was no storage bag present on the wheelchair. Another wheelchair outside Resident L's room was observed with a nasal cannula attached to a portable oxygen tank. The cannula was observed tucked into a pocket on the back of the wheelchair that was part of the seat. There was no storage bag present on the wheelchair. During an interview with Resident J on 3/21/25 at 10:29 a.m., an oxygen concentrator was observed in the resident's room with the tubing and nasal cannula rolled up and anchored under the handle of the device. There was no dated storage bag on the machine. Resident J indicated there was no bag provided to store her cannula when she was not using it. During an interview on 3/21/25 at 12:09 p.m., the Assistant Director of Nursing/Infection Preventionist indicated the oxygen concentrators should all have dated storage bags on them for	F 0695	PROPOSED PLAN OF CORRECTION F695 It is the practice of this facility to provide and maintain dated storage bags for oxygen administration equipment to be stored in a clean manner. 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 practice, the facility immediately audited each resident with oxygen administration equipment and made sure their equipment had dated bags in place. b. Identified residents K, L, J had a dated bag placed for the oxygen equipment to be stored in when not in use. 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 who are on oxygen have the potential to be affected by the alleged deficient	04/11/2025

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	03/21/2025

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
	the tubing to be stored when not in use. The portable oxygen tanks should also have dated storage bags. There were a couple of residents who continually took the bags off the wheelchairs or concentrators. A current facility policy, revised 1/2023, titled, "Oxygen Administration," provided by the Administrator on 3/21/25 at 4:06 p.m., indicated the following: "Procedure.....11. Oxygen tubing and bag are to be changed and dated every week." 3.1-47(a)(6)		practice. b. An audit was completed and each resident identified with oxygen administration equipment to ensure dated bags were provided and in place. 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 conducted on 4/10/2025 with nursing staff regarding the policy of dated, bagged oxygen administration equipment. 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 a - The DON or designee will conduct an audit of all residents on oxygen to ensure equipment is stored, changed, and dated per policy. This audit will then be conducted twice per week for 12 weeks. Any issues identified will be immediately addressed. As a means of quality assurance, the results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months. Monitoring will continue as planned or will be increased by the Quality	

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	03/21/2025

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
			Assurance Committee if needed to obtain 100% compliance. 5 – Corrective action completed by 04/11/2025.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to maintain a clean, orderly shower room for resident use for 1 of 4 shower rooms observed for cleanliness. (100 East hall) Findings include: During an observation of the 100 East hall shower room on 3/20/25 at 10:16 a.m., the following was observed: the floor was soiled and had standing water from the shower to the sink. There were two open soda cans and a plastic bottle of a hydration drink on a shelf. There were plastic wrappers and a bottle of powder in the dirty sink. The toilet bowl had dark rings around the water line. The trash container was uncovered, and a bag of linens was observed on the floor next to the trash container. A sheet was observed draped over the seat of a shower chair and onto the floor. During an observation of the 100 East hall shower room on 3/21/25 at 1:52 p.m., accompanied by the Housekeeping Manager and the Unit Manager, the following was observed: multiple smears of feces on the floor from the shower to the sink, sink visibly dirty, and the toilet bowl had dark rings around the waterline. There were light colored smears on the toilet seat.	F 0880	PROPOSED PLAN OF CORRECTION F880 It is the practice of this facility to maintain a clean, orderly shower room for resident use. 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 practice, the shower room was deep cleaned immediately. 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 could be affected by the alleged deficient practice. 3 – What measures will be put into place and what systemic changes will be made to ensure	04/11/2025

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	03/21/2025

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 at the time of the observation, the Housekeeping Manager indicated the shower rooms should not be in this condition and was an unacceptable way to leave the shower room. A current facility schedule for 3/2025, provide by the Administrator on 3/21/25 at 4:07 p.m., included: "...*make sure you are getting your shower rooms....Daily...shower rooms." This Federal tag relates to complaint IN00454626. 3.1-18(a)		that the deficient practice does not recur: a – An in-service was conducted on 4/10/2025 with nursing staff and housekeeping staff regarding the policy and expectations of infection control. 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 DON or designee AND the housekeeping supervisor will conduct an audit of all shower rooms to ensure they are clean and orderly. This audit will then be conducted daily during administrative rounds (Monday through Friday) for 12 weeks. Any issues identified will be immediately addressed. As a means of quality assurance, the results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. 5 – Corrective action completed by 04/11/2025.	