STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/04/2022			LETED	
	PROVIDER OR SUPPLIE			4600 E	ADDRESS, CITY, STATE, ZIP COD JACKSON ST E, IN 47303		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI		ATE	(X5) COMPLETION
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
Bldg. 00 This visit was for the Investigation of Complaint IN00387005. Complaint IN00387005 - Substantiated.		F 00	000				
	Federal/state deficiencies related to the allegations are cited at F689. Survey dates: August 4, 2022						
	Facility number: 000269 Provider number: 155400 AIM number: 100267720						
	Census Bed Type: SNF/NF: 37 Total: 37						
	Census Payor Type Medicare: 4 Medicaid: 32 Other: 1 Total: 37	e:					
	accordance with 41						
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervis §483.25(d) Accid The facility must §483.25(d)(1) The	ents.					

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

(X6) DATE

TITLE

Any defiency statement 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 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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/04/2022 155400 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4600 E JACKSON ST CARDINAL CARE STRATEGIES MUNCIE. IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record F 0689 Plan of Correction: 08/26/2022 review the facility failed to ensure staff operated The filing of the plan of correction the mechanical lift in accordance with facility does not constitute an admission policy (Resident E) and followed facility policy for that the alleged deficiency did in use of gait belts for resident transfers (Resident B) fact exist. This plan of correction for 2 of 4 residents reviewed for safe transfers. is filed as evidence of the facility's desire to comply) with the Findings include: requirements and continue to provide quality care. 1. The clinical record for Resident B was reviewed The facility requests paper review on 8/4/2022 at 8:54 a.m. Diagnoses included, but for compliance. were not limited to, muscle weakness, paranoid What the facility did for the schizophrenia, morbid obesity, lumbar spinal resident identified: bifida, and chronic obstructive pulmonary Resident B was sent to the ER and returned with orders to wear an immobilizer. The resident's The most recent quarterly Minimum Data Set care plan and Kardex was updated (MDS) assessment, dated 7/19/2022, was reviewed to reflect the need for a on 8/4/2022 at 8:54 a.m. The resident required Mechanical Lift transfer while extensive assistance of 2 persons for bed mobility wearing the immobilizer. The use and toilet use. The resident required total of the Mechanical lift for transfers assistance of two persons for transfers. will be reassessed at least quarterly and for significant During an interview 8/4/2022 at 9:30 a.m., CNA 1 change. indicated during a two person transfer Resident How the facility identified others: B's left knee bent and she was lowered to the The facility IDT completed an audit wheelchair. "We picked her up and turned of all residents to determine the sideways." The CNA indicated she and NA 2 need for mechanical lift/Gait Belts. were able to keep the resident upright and the Any residents identified requiring resident did not fall. mechanical lift for transfer/Gait Belt, the resident care plans were During an interview on 8/4/2022 at 10:11 a.m., NA updated and communicated to 2 indicated she and CNA 1 transferred Resident B nursing staff via resident Kardex. from the bed to the wheelchair. The mechanical Therapy screens were completed lift was unavailable and was not used for the on those residents identified b'. transfer. NA 2 indicated they did not use gait the IDT for need for Mechanical

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belts for the transfer. NA 2 indicated staff were

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Lift/Gait Belts.

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r í		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			RVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>			COMPLETED	
		155400	B. W	'ING		08/04/20)22	
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	L.			JACKSON ST			
CARDIN	AL CARE STRATE	GIES			IE, IN 47303			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		t belts for resident transfers			System:			
	and ambulation.				An Inservice was provided for	the		
					nursing staff regarding safe			
	_	7 on 8/4/2022 at 10:49 a.m.,			transfers utilizing a mechanica	al lift		
		edication Aide) 3 indicated			and use of gai" belt.			
		have been transferred using a			Therapy screens will be comp			
		have always transferred her			on all residents quarterly and	for		
	· ·	is what I have been told in			significant change.			
	1 -	d working here." She			Therapy will communicate to t	he		
		B was a total assist of 2			IDT any recommendations or			
	1 ~	s. She indicated she has			instructions as a result of the			
	_	n with mechanical lift			quarterly screens or during			
	availability.				therapy treatment.			
					Care plans and Kardex will be			
	1	on 8/4/2022 at 11:29 a.m.,			updated as needed as per the	-		
		Resident B had been			to reflect, the recommendation			
	_	erapy in July 2022 due to			for transfers utilizing a Gait Be	elt or		
		t the time of discharge the			Mechanical lift.			
	_	e assistance of 2 persons for			Care plans will continue to be			
	transfers.				reviewed at least quarterly and	d for		
					significant change by the for			
	1	investigation dated 8/1/2022,			additional transfer intervention	is.		
		reported a fall and complained			How the facility will monitor:			
	_	he facility obtained an in			Facility will complete proficien	су		
	1	s non-conclusive. The facility			observations of nursing staff			
		ician with the x-ray results and			•utilizing the Mechanical Lift/G			
		send the resident to the			Belts for transfers at random t			
	_	ion and treatment on 8/2/2022.			on residents identified for the			
		ed to the facility with a			of Mechanical Lift/Gait Belts.	- I		
	diagnosis of a fracti	ared left patella.			issues identified as a result of	the		
	0.71 11 1.5	10 P :1 (F			proficiencies; the identified	.		
		ord for Resident E was			employee will be reinserviced			
		22 at 9:47 a.m. Diagnoses			least two proficiency observat			
		not limited to, diabetes type 2,			will be performed 5 days a we			
	anxiety, depression	and nypertension.			on random staff and residents			
	TEI .	A L MCC			require a Gait Belt Mechanica			
		arterly Minimum Data Set			for transfers as determined by			
		dated 5/9/2022, was on			care plan. These proficiencies			
		n. The resident required			be coordinated and monitored	-		
	extensive assistance	e of two persons for bed			the Director of Nursing)design	nee.		

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED			
		155400	B. WING 08/04/2022				
	PROVIDER OR SUPPLIER		<u> </u>	4600 E	ADDRESS, CITY, STATE, ZIP COD JACKSON ST E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
	·				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
					The proficiencies will be review		
TAG	mobility and transfer During an observation CNA 1 and NA 2 we Resident E using a state the wheelchair. The the legs for stabilizaresident from the begindicated they would once they had the rewheelchair. Review of a skilled DON on 8/4/2022 a mechanical lift legs position and the bre resident in the sling.	ers. Ion on 8/4/2022 at 9:20 a.m., were observed transferring mechanical lift from the bed to e staff members did not expand ation of the lift while lifting the ed. The staff members d expand the legs of the lift esident positioned over the check list provided by the t 1:33 p.m., indicated the were to be placed in the widest aks set before placing the		TAG	The proficiencies will be review in the QAPI meeting monthly f months. Completed 8/24/22 Resident Care Level	wed for 6 d	
					-D Wright, Lori (68) LTC Medicaid Occupied Unit: HALL A, HALL B. HALL I Floor: 1 Date: 81231',,J22 108	E	
					w Dishman, Roberta (50) I-TC Medicaid Occupied		

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	OF HEALTH AND HU					ORM APPROVED MB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 00 155400 B. WING			(X3) DATE	
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(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	MUN PREFIX TAG	Jack (2) LTC Medicaid Occupied 109 -w Hall, Frederick LTC Medicaid Occupi Empty 110 -w Empty	eé4)	(X5) COMPLETION DATE
				Occupied 13 Empty 10		

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Unpa.d Mason, Nila (6)

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Mildred (36) 114 -D

June (18)

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155400	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/04/2022
	PROVIDER OR SUPPLIER		4600 E	ADDRESS, CITY, STATE, ZIP COD JACKSON ST IE, IN 47303	
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				Unit: HALL HALL B, HALL E Floor: Date: 8123/2022	
				Roorn-Bed Resident Care Level Primary Payer Bed Status Confirmed Unit - HALL B	
				Kendall, James (15) LTC Medicaid Occupied 115-w GARRETT, ERNES (80) ETC Medicaid Pending Occupied 116 -w 118 -w 119 -W 4 20 - w 12 -w 122 -D 122 -w Nash, Linda (59) Turner, Terry (33) Haffner, James U) Goodman, Steven (58) Skinner, Teresa (43) Hoffman, Kevin (35) Sciscoe, Susan (20) Upchurch, Judith (29) LTC	Т

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155400	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/04/2022
	ROVIDER OR SUPPLIE		4600 E	ADDRESS, CITY, STATE, ZIP COD JACKSON ST IE, IN 47303	
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				Occupied 14	

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301 -D

301 -w 302 -D

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Empty

Empty 302 - w Frank,

Empty

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DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FOI	RM APPROVED
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155400	B. WI	NG		08/04/	2022
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
	no (IDDIT ON DOLL DIDI	•		4600 E	JACKSON ST		
CARDINA	AL CARE STRATE	GIES		MUNCII	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 CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
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CARDINAL CARE STRATEGIES			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		
TAG	REGULATORY OR ESC IDENTIFYING INFORMATION	IAG	Harry (? ITC Medicaid Occupied	DATE		
			303 -D Empty 303 - w BANTER, DAVID			
			(82) LTC Medicaid			
			Occupied 304 - D Empty			
			304 - w Hold-Unpaid			
			305 -D Moerbe, Tamborah (60) LTC Medicaid			
			Occupied			
			305 - w Empty 306 -D MILLS, ELAINE			
			(81) STD Private			
			Pay Occupied 306			
			-W			
			Empty			
			Occupied			
			10			
			Empty 11 Hold I			
			Facitity Totals Unit: HALL A, HALL B, HALL E			
			Floor: Date: 812312022			
			Room-Bed			
			Resident			
			Care Level Primary Payer			
			Bed Status			
			Confirmed Unit - HALL E			

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CENTERS FOR MEDICARE & MEDIC	AID SERVICES		(
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155400	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 08/04/2022	
	PROVIDER OR SUPPLIER			4600 E	ADDRESS, CITY, STATE, ZIP COD JACKSON ST E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
					307 -D 307 - w 308 -D 308 -W 309 -D 309 - w 310- 0 310 -w 31 4 -w Yadon, Richard ,67) Buchanan. Christopher (87) Toy. William (49) Weber, Robed (95) Sterling• . (55) Thomas. Patricia (90) LTC ITC LTC LTC LTC LTC Medicaid Medicaid Medicaid Medicaid Medicaid Medicaid Medicaid Medicaid Medicaid Occupied Empty Occupied Occupied Cocupied Occupied Empty Oncupied Empty Occupied Empty Unit Totals		

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CENTERS FOR	MEDICARE & MEDICAID SERVICES	

	OF CORRECTION	IDENTIFICATION NUMBER 155400		LDING	00	COMPL 08/04/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303				
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					Occupied 37 Empty 27 Hold 2 Unpad Actual Physical Head Count Physical Count Date Certified by for Resident with Occupied status. INSERVICE ATTENDANCE TOPIC		
					DATE -AR- SPEAKER/TITLE TIME STARTED TIME, ENDED Atawh handou,s If provided an pre/ post test or other assessm of learning prou ided.		

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	DEPARTMENT OF HEALTH AND HU	FORM A		
•	CENTERS FOR MEDICARE & MEDIC	CAID SERVICES		OMB No
	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SUR

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/04/2022	
	ROVIDER OR SUPPLIE		4600 E	ADDRESS, CITY, STATE, ZIP COD E JACKSON ST IE, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
				I .52 INSERVICE ATTENDANCE TOPIC		
				DATE SPEAKER/TITLE		
				CONTENT TIME STARTED TIME ENDED		
				Attach han outs if provided aud pre/ post test or other assessm of learning provided. FORM 0003 MECHANICAL LIFT		
				STEP Satisfactory Unsatisfactory 1. Inspect the mechanical lift before each use. Make certain brakes en a e and base can be easil widened		
				2. Gather necessar) items. suc	h	

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	OF HEALTH AND HU MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2022	
	ROVIDER OR SUPPLIE		4600 E	ADDRESS, CITY, STATE, ZIP COD E JACKSON ST IE, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				as slings, chains or straps and wheelchair or be.:side chair is ready. If wheelchair is the destinatiom make certain whe are in the locked position prior transfer. 3. Posinon resident to the cert of the bed. Turn resident to the side. 4. Center sling under residen, the lower edge of seat 31ightly below the resident's knees. 3. Raise head of bed as needed. 6. Roll the lift to bedside, raise and place with open end of the base under the bed positioning overhead har directly over the	els to ter e with y ed. it e g the
				resident. 7. Widen the base orthe lift.	

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8. Attach the shng to the straps or chains by hooking the shor, side to sling at the resident's back and the long side he resident's thi hs.

-sition resident's arms overthe

chest or in the la

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED	
155400			B. WING		08/04/2022
NAME OF D	DOVIDED OD SUDDIJEI		STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	ROVIDER OR SUPPLIEF			JACKSON ST	
CARDINA	AL CARE STRATE	GIES	MUNC	IE, IN 47303	
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	T BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				40 D 41 - 134	_
				10. Pump the litt nandle or rais with remote until resident clear	
				the bed. NOTE* Be sure to	S
				support resident's head neck,	and
				Support resident s fload floor, t	
				Roll the lift slowly away from b	ed
				and toward the chair. Have you	
				assistant guide the resident's	
				body gently until resident is dir	ectl
				over chair seat. Lock mechanic	cal
				lift brakes.	
				12, Slowly lower resident into	
				chair while your assistant	
				continues t" ide his,her bod .	
				40.5	
				13. Detach the chains or stra s	5,
				leavin slin beneath resident.	
				14. Ad •ust footrests, if indicate	ed.
				TO ASSIST BACK TO BED:	
				15. Roll lift to resident's chair a widen base.	and
				16. Attach the slin stra s	S

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. Position resident's arms over the

chest or in the la

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155400	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/04/2022			
	PROVIDER OR SUPPLIEF		4600 E	STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE			
				18. Pump the lift handle or use remote until resident clears th chair. NOTE: Re sure to su or resident's head, neck, and fee	e t			
				19. Roll lift awa from the chair back to the bed.	and			
				20. Center resident over the b	ied.			
				21. Lower resident onto bed				
				22. Unhook sling and remove beneath resident by turning resident from side to side.	from			
				I verify that this procedure wa taught and successfully demonstrated.	s			
				MECHANICAL LIFT STEP Satisfactory Unsatisfactory 1. Inspect the mechanical lift before each us Make certain brakes en a e ar base can be easil widened 2. Gather necessary items. such as slings, chains of straps and wheelchair or beds chair is ready. If Wheelchair is destination make certain wheel are in the locked position prior	or side s the els			

transfer.

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

PRINTED: 09/07/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/04/2022				
NAME OF PROVIDER OR SUPPLIER CARDINAL CARE STRATEGIES			4600 E	STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE			
				3. Position resident 1 the center oftne bed. Turn resident to the side. 4. Center sling under resident with the lower edge of seat slightly below the resident knees. 5 Raise head of bed aneedea. o. Roll the lift to bedside, raise and place with open end of the base under the bed positioning overhead bar direcuy over the resident. 7. Widenthe base of the straps or chains by hooking the short side to sling at the reside back and the long side at the resident's think. 9. Position resident's arms over the chest or in the 10. Pump the lift nandle or raise were remote until resident clears the bed. NOTE* Be sure to support resident's head neck, and feet 11. Roll the lift slowly away from bed and toward the chait Have yc•n• assistant guide the resident's body gently until resident is directl over chair stock mechanical lift brakes. 1 Slowly lower resident into chawhile your assistant continues ide his/her bod. 13. Detach the chains or stral leavin slin beneath resident. 14. Ad •ust foofrests, If indicator ASSIST BACK TO BED:	of int's selection in the content of			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
155400			B. WING		08/04/2022	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD JACKSON ST		
CARDINA	AL CARE STRATE	GIES	MUNCI	E, IN 47303		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	(X5) COMPLETION		
TAG	`	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
				1.5. Roll I ift to re-ident's chair widen base. 16. Attach the slin to the stra s or chains. 17. Position resident's arms over the chest or m the I. 18. Pump the lift handle use remote until resident clear the r*h.air NOTE: Be sure to s resident's head, neck, and fee 19. Roll lift awa from the chair and back to the bed. 20. Center resident over bed. 21. Lower resident onto bed. 22. Unhook sling and remove from beneath resident turning resident from side to si 1 verify that this proc ure was taught d succe fully dem strate CNANurse MECHANICAL LIFT STEP Satisfa*-tory Unsatisfactor* 1. Inspect the mechanical lift before each use. Make certain brakes en a e and base can be easil widened	a or se u ort t, e e r tne e e e e e e e e e e e e e e e e e e	
				2. Gather necessary' Items. su as slings, chains or straps and wheelchair or bedside chair is ready. If wheelchair is the destination make certain wheel are in the locked position prior	l els	

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transfer

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STATEMENT OF DEFICIENCIES		i '		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155400	B. WI	ING		08/04/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t .			JACKSON ST		
CARDINA	AL CARE STRATE	GIES		MUNCI	E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCT!		DATE
					n . Position resident 10 the ce	nter	
					oftne bed. 'lum resident to the		
					side.		
					4. Center sling under resident	with	
					the lower edge of seat slightly		
					below the resident's knees.		
					5. Raise head of bed as neede	-d	
					S. Haise fload of bod as flood		
					6. Roll the lift to bedside, raise	ı it	
					and place with open end of the		
					base under the bed positioning		
					overhead bar directly over the		
					resident		
					Widen the base of the lift.		
					8. Attacn the sling to the strap	s or	
					chains by hooking the short si		
					to sling at the resident's back		
					the long side the resident's thi		
					9. Position resident's arms over	⊇r	
					the chest or in the la .	5 1	
					10. Pump the liri handle or ran	20	
					witn remote until resident clea		
					the bed. NOTE* Be sure to		
					support resident's head neck a	and	

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feet.

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155400	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/04/2022
	PROVIDER OR SUPPLIE		4600 E	ADDRESS, CITY, STATE, ZIP COD JACKSON ST IE, IN 47303	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				11. Roll the lift slnwly away from bed and toward the chair. Have your assistant guide the resident body gently until resident is discover char seat. Lock mechanical lift brakes.	re ent's rectl
				12. Slowly lower resident into chair while your assistant continues to ide his/her bod .	
				13. Detach the chains or stra steading slin beneath resident.	5,
				Ad•ust footrests, If indicated.	
				TO ASSIST BACK TO BED	
				15. Rol I lift to resident's chair widen base.	and
				16. Attach the slin to the stra s chains.	s or
				1 Position resident's arms ove chest or in the la	r the
				p the lift handle or use remote	until

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resident clears the ch n ;r. NOTE' Be sure to su ort resident's head,

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED	
		155400	B. WI	NG		08/04/	2022	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	8			JACKSON ST			
CARDINA	AL CARE STRATE(GIFS			E, IN 47303			
O, ((C) (V)				WIGHTON	_, +1000			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	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	
					neck, and feet.			
					19. Roll lift awa from the chair	and		
					back to the bed.			
					20. Center resident over the b	ea.		
					21 Lower resident anta bad			
					21. Lower resident onto bed.			
					22. I-Jrü100k sling and remove	2		
					from beneath resident by turni			
					resident from side to side.	ıı9		
					resident from side to side.			
					MECHANICAL Lift			
					<u></u>			
					STEP			
					Satisfactory U			
					nsatisfactory			
					I . Inspect the mechanical lift			
					before each use. Make certair	l		
					brakes em. a e and base can	be		
					easil widened			
					2. Gather necessary			
					items. such as slings, chains o	or		
					straps and wheelchair or beds	ide		
					chair is ready. If wheelchair is	the		
					destination, make certain whe	els		
					are in thc locked position prior	to		
					trane fer.			
					Position resiaent to			
					the center ofthe bea. Turn resi	ident		
					to the side.			
					4. Center sling under			
					resident with the loweredge of	sea,		
					slightly below the resident's			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155400 B. WING 08/04/2022 STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST CARDINAL CARE STRATEGIES MUNCIE, IN 47303
155400 B. WING 08/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST 4600 E JACKSON ST
155400 B. WING 08/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST 4600 E JACKSON ST
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST
NAME OF PROVIDER OR SUPPLIER 4600 E JACKSON ST
4600 E JACKSON ST
CARDINAL CARE STRATEGIES MUNCIE, IN 47303
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID MONUMERS IN AN OF CORPORTION (X5)
PREFIX (FACH DEFICIENCY MIST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
knees.
5. Raise head of bed as
needed.
6. Roll the lift to bedside,
raise it and place with open end of
the base under the bed positioning
the overhead bar directly over the
resident.
7. Widen the base of the
lift.
8. Attach the sling to the
straps or chains by hooking the
short side to sling at the resident's
back and the long side at the
resident's thi hs.
9. Position resident's
arms over the chest or in the la .
10.
Pump the lift handle or raise with
remote until resident clears the
bed. NOTE* Be sure to support
resident's head neck, and feet.
1. Roll the lift slowly away from
bed and towardthe chair. Have
your assistant guide the resident's
body gently until resident is directl
over chair seat. r ock mechanica-
lift brakes. 12. Slowly lower
resident into chair while your
assistant continues to ide his/her
bod
3. Detach the chains or stra s,
leavin slin beneath resident.
14. Ad •ust footrests, ii indicated.
TO ASSIST BACK TO BED:
1 5 Roll lift t" resident's chair and
į į 1 5 koli lilt tiesidents chair and i i
widen base.

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or chains.

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I m . Position resident's arms over

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155400	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/04/2022		
NAME OF PROVIDER OR SUPPLIER CARDINAL CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	(X5) COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	the chest or m the la 18. Pump the lift handle us' remote until resident clears chair. NOTE: Be sure to su or resident's head, neck, and fee 19. Roll lift awa from the chair and back to the bed. 20. Center resident over bed. 21. Lower resident onto ing and remove from beneath resident by turning resi fr 1 s I ve h this p cedu was ught nd successfully demonstr MECHANICAL LIFT Satisfactory Unsatisfactory I. Inspect the mechanical lift before each use. Make certain krakes en e and base can oe of widened 2. Gather necessary items. su as slings. chains or sfraps and wheelchair or bedside chair i- ready. If wheelchair is the destination, mal.e certain whe are in the locked position priet transfer. 3. Position resident to the cen- of the bea. Turn resident to the	s the total the bed. The bed. The easil the bed. The easil the bed. The bed bed. The bed bed bed bed bed bed bed bed bed be		

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side.

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EPARTMENT OF HEALTH AND HU	FORM APPROVE					
ENTERS FOR MEDICARE & MEDIC	IEDICARE & MEDICAID SERVICES OMB NO. 0					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED			
	155400	B. WING	08/04/2022			

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4600 E JACKSON ST

CARDINAL CARE STRATEGIES			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		
			4. Center sling under residentwith the lower edge of seat slightly below the reaident's knees.			
			5. Raise head of bed as needed.			
			O. Roll the lirt to bedside, raise it and place with openend of the base under the bed positioning the overhead bar directly over the resident			
			7. Widen the base of the lift.			
			8. Attach the sling to the straps or chains by hookingthe short side to sling at the resident's back and the long side dt the resident's thi hs			
			9 Position resident's arms over the chest or 'n the			
			10. Pump the lift handle or raise with remote until resident clears the oed. NOTE* Be sure to support resident's head, neck, and feet.			
			II. Roll the lift slowly away from			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
1554		155400	B. WING			08/04/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			JACKSON ST		
CARDINAL CARE STRATEGIES		MUNCIE, IN 47303					
(X4) ID	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 CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					bed and toward the chair. Hav	е	
					ycnr assistant guide the reside	nt's	
					body gently until resident is dir	ectl	
					over chair seat. Lock mechani	ca•	
					lift brakes.		
					12. Slowly lower resident into		
					chair while your assistant		
					continuee fo ide his/her bod		
					13. tach the chams or stra	s,	
					leavin slin beneath resident		
					14. Ad•ust footrests, if indicate	h .	
					Trivia doctionation, il illustration	· G.	
					TO ASSIST BACK TO BED:		
					Roll lift t" resident's cha;" and		
					widen base.		
					40 44		
					16. Attach the slin to the stra s	or	
					chains.		
					17. Position resiaenvs arms ov	√er	
					the chest or in the la		
					18. Pump the lift handle or use)	
					remote until resident clears the		
					chair. NOTE: Be sure V, su rt		

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resident's head neck, nnd feet.

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CENTERSTOR	C MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0/38-03/
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED
		155400	B. WING		08/04/2022
	PROVIDER OR SUPPLIE		4600 E	ADDRESS, CITY, STATE, ZIP COD	
CARDINA	AL CARE STRATE	:GIES	MUNC	IE, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				10 Roll lift awa from the charr back to the bed.	and
				20. Center resident over the b	ed.
				21. Lower resident onto bed.	
				22. Unhook sling and remove beneath residen, by turning resident from side to side.	from
				MECHANICAL LIFT	
				STEP	

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