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	04/14/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00405975 and IN00405772. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00405975 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00405772 - No deficiencies related to the allegations are cited. Survey dates: April 12, 13 and 14, 2023. Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 4 Medicaid: 48 Other: 5 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 18, 2023.	F 0000		
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamey Kleva	Health Facility Administrator	04/24/2023

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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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to ensure a resident with known suicidal ideations with plastic bags had interventions in place, including no access to plastic bags for 1 of 3 resident reviewed for accidents (Resident C). The Immediate Jeopardy began on 4/11/23 when a resident with previous suicidal ideations with plastic bags was found by staff applying a plastic bag to her head. During an observation of the resident's room, on 4/13/23, there were plastic bags observed in two trash cans. The DON, ADON, SSD and Medical Records Nurse were notified of the Immediate Jeopardy on 4/13/23 at 3:23 p.m. The Immediate Jeopardy was removed on 4/14/23, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on observation, interview and record review, the facility failed to follow the facility's fall protocol for a resident who had a fall with fracture (Resident E) for 1 of 3 residents reviewed for accidents. Findings include: A. Resident C's clinical record was reviewed on 4/12/23 at 10:50 a.m. Diagnoses included unspecified mood [affective] disorder, major depressive disorder, recurrent, moderate,	F 0689	F0689 (A) Suicide Ideation 1. Immediate actions taken for those residents found to be affected by the alleged deficient practice. a. Resident was found to have moment on suicidal thoughts and was placed on 1:1 until NP was notified and sent out to BMH for evaluation. Once cleared by psychiatric medical professional resident was safely sent back to facility. b. Suicidal precautions were initiated upon return per request of facility NP for 72 hours these interventions include; 15 minute checks, removing any object that could be used to self-harm including plastic bags, paper bags will be used for trash ongoing and or until cleared of suicidal ideations by medical professional. c. Staff was educated on suicidal precautions and the policy for suicidal ideations. d. Linen cart will be stored in Linen room to prevent free access to multiple plastic bags. e. Careplan updated to reflect interventions put into place. 2. How others were identified.	04/21/2023

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	depressive disorder, recurrent, borderline personality disorder, mild cognitive impairment of uncertain or unknown etiology, major depressive disorder, recurrent, severe with psychotic symptoms, schizoaffective disorder, bipolar disorder, generalized anxiety disorder, and suicidal ideations. Her current medications included, quetiapine fumarate (antipsychotic) 100 mg (milligram) in the morning, quetiapine fumarate 300 mg at bedtime, trazodone (treat insomnia) 50 mg daily, clonazepam (treat anxiety) 0.5 mg twice daily, and lithium carbonate (treat borderline personality disorder) 150 mg twice daily. A quarterly MDS (Minimum Data Set) assessment, dated 2/1/23, indicated she was cognitively intact. Her PHQ-9 (questionnaire for depression) was normal, she did not have thoughts she would be better off dead or hurting herself in some way. She had verbal behavior symptoms directed towards other (e.g., threatening others, screaming at others, cursing at others) that occurred one to three days during the assessment period. She required supervision of one staff member for bed mobility, locomotion on and off the unit, dressing, eating and personal hygiene. She required extensive assistance of two staff members for toileting. She had a current, 10/7/22, care plan for diagnosis of depression and had a history of symptoms such as negative statements, sad mood, tearfulness, and suicidal ideation. She voiced feelings of being down, depressed, hopeless and a poor appetite during the assessment. Her goal was her overall mood would improve AEB (as evidenced by), her PHQ-9 score of less than three (normal) during the next review. Her interventions		a. All interviewable residents have been questioned regarding suicidal thoughts completed 4/14/23 completed by 10:00 am. 3. Systems in place a. A reinservice for staff will be completed on _4/13_ for Suicidal precautions, facilities updated suicidal policy, and signs of depression. The staff has been instructed to notify charge nurse immediately of any signs or symptoms of suicidal ideations/self harm. Residents will be placed on 1:1 until MD/NP can be reached for further assessment. Orders will be implemented at the time received. b. Any threat of self-harm will be immediately relayed to Psych NP Beverly Maugher where a tela-med visit (if not in building) will take place, and further direction will occur. c. Careplan for this resident will be updated at the end of 72 hours as ordered Beverly Maugher, NP 4. How the facility will monitor and quality assurance measures put into place are: a. The DON/designee will complete audit tool to ensure 15 minute suicidal precautions checks are being completed for the identified resident with orders for 72 hour monitoring as ordered by the NP. b. Charge nurse/designee will complete Audit tool ensuring linen cart is being kept in linen room	

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	were to encourage her out of her room for activities (10/7/22), medication per physician orders and monitor for side effects (10/07/22), and no trash bags in her room (3/7/23). She had a current, 10/7/22, care plan for voiced suicidal ideations AEB recent psychiatric stay due to suicidal ideation. Her goal was she would not harm herself through next review. Her interventions were to allow her to voice all concerns (10/7/23), notify the physician and her representative of new or continued verbalization of ideations (10/7/22), and provide one on one visits as needed (10/7/22). Review of nurses notes indicated the following: On 2/28/23 at 10:55 a.m., a behavior note indicated the nurse knocked and entered her room to give her insulin. She was in bed with a plastic bag loosely over her head, it was not secured around her neck. She was alert and oriented to person, place and time. The nurse immediately removed the bag and asked her what she was doing, she stated no one cared about her, she just wanted to die. The SSD (Social Service Director), Administrator and DON was notified. She was brought out to the nurse's station with the SSD. A 2/28/23 behavior note indicated she had been found in bed at 10:55 a.m. with a bag over her head. The SSD and DON met with her, she had a flat affect and voiced she was extremely depressed, and if her son didn't care about her, then why should she care about herself. She was unable to get ahold of her son and upset he would not buy her clothing. It was explained to her her son had lost his phone and he was doing the best to care for her needs. The psychiatric NP and physician were notified. The SSD did one on one		and that no trash bag rolls are left on nursing carts every shift for 4 weeks or until identified resident is discharged to appropriate care facility. c. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted. B. Failure to follow facility's fall protocol 1. Immediate actions taken for those residents found to be affected by the alleged deficient practice. a. LPN 16 received disciplinary action -teachable moment form completed 4/13/23-by DON for not following facility fall protocol after being educated. b. Nursing staff rein-serviced on proper procedures on completing facility's fall protocol on ___4/17/23___. 2. How others are identified a. Review all falls daily during stand up meeting to ensure proper interventions are being administered by completing the falls check off list. (exhibit A) b. Therapy to screen all residents identified in stand up meeting that are at risk for falls. Therapy to report at proceeding stand up meeting the outcome of the screen. 3. Measures and systemic changes put into place to ensure the at the alleged deficient	

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	visits with her until the EMTs arrived. She was sent to the ER for an evaluation. Review of a hospital HPI (history of present illness) document, dated 2/28/23 at 12:31 p.m., indicated the history was provided by the patient and the nursing home staff. She presented to the ER with complaints of suicidal ideation. She reported she had not been able to get in touch with her son, and this had increased her depression. She stated she had put a trash bag over her head in an attempt to kill herself. She denied previous attempts to kill herself. Staff at the nursing home reported she saw the nurse walking into a room and she pulled a bag over her head, and the bag was on her head for less than 30 seconds. On 3/7/23 at 3:10 p.m., she returned to the facility from the hospital. She continued to state she didn't want to come back to the facility. Her son didn't buy her anything, etc. Trash bags were removed from her room. On 3/7/23 at 10:03 p.m., she continued past behaviors. She was unwilling to talk. She stated she had no pain medication and refused hydrocodone. She desired to return to the hospital. On 4/10/23 at 10:03 p.m., she had tried to call her son multiple times with no answer. She exhibited attention seeking behaviors. She refused her evening medications. She came to the nurses' station and stated she wanted to go to the hospital because she was depressed and refused her night medications. The Psychiatric NP (Nurse Practitioner) was called with orders received for her to be monitored and put on 15 minute checks. The SSD was made aware.		practice does not recur. a. A mandatory in-service will be completed on 4/17/23 with Nursing staff for fall interventions. b. During daily nursing rounds, the charge nurse will monitor that the fall interventions are in place. If any issues are identified, immediate action will be taken to resolve. c. DON and/or Designee will complete rounds and document findings on units to ensure that fall interventions are in place. If any issues are identified, immediate action will be taken to resolve. 4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are: a. DON and/or Designee will complete rounds and document findings on units to ensure that fall interventions are in place. If any issues are identified, immediate action will be taken to resolve. These audits will be completed 3 times a week for 4 weeks, then 3 times weekly for 60 days, and then monthly for three quarters, to identify any concerns and take corrective measures. b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted. c. Initiated Falls meeting with IDT weekly to implement interventions	

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	On 4/11/23 at 4:56 p.m., the QMA called the nurse to her room. The resident requested to be sent to the hospital because she was in pain. She reported she was unable to get pain medication like the other residents in the facility. Her hands were slightly shaking. She was hurting all over, especially her head. Her vital signs were within limits. The NP was made aware, with no new orders. They would continue to monitor her. On 4/11/23 at 8:05 p.m., she continued to complain about her pain, and she was offered acetaminophen (pain reliever). She refused and stated it would not help her, she wanted the pain medication she was promised. She was very upset, she said she needed to use the phone, and proceeded to call 911 to have them take her to the ER. She continued with attention seeking behaviors. The NP was called and an order was received to send her to the ER for evaluation and treatment. All parties were notified. The history of present illness from the local hospital dated 4/11/23 at 9:48 p.m., indicated she had suicidal ideations, with multiple attempts over the last six months and had attempted again today, when she placed a plastic bag over her head. She stated the reason for being suicidal was she did not like the facility she resided in currently. She felt the nurses were mean and did not give her adequate pain medication. She stated she would continue to attempt suicide if she was returned to the facility. During an interview with Resident C, on 4/12/23 at 1:42 p.m., she indicated she had gone to the hospital the previous night because she had put a bag over her head and she was brought back to the facility. The nurses and doctors were not		to keep residents safe for those at risk for falls. d. Administrator/DON/or designee to use audit tool to assure that the Falls are being addressed by IDT team.	

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	good at the facility. They refused to give her any of her medications. She had a headache and they wanted to give her acetaminophen and it did not work for her. She was going to live the rest of her life in her room with no showers or nothing and she would die in this facility. During the interview with Resident C, there was a plastic bag observed in her trash can near her nightstand and a plastic bag in her bathroom trash can. During an interview, on 4/12/23 at 1:52 p.m., LPN 31 indicated it was different every other day for Resident C, as she would have a good day, then a bad day. It mattered how much attention she received, or if she didn't get the answers she wanted. She got obsessive with topics, such as not having shoes, clothing or bras. Her family lived out of state. She complained about clothes, when she received new clothes, she felt they were not the right size. She received the right sized clothes but she then threw them away or gave them away. Last night (4/11/23) she put a bag over her head. They were doing 15 minute checks on her. She was sent to the hospital and they put her on an antibiotic for a urinary tract infection. They had found towels and washcloths in her room and rolls of plastic bags. During an interview with the Housekeeping Supervisor, on 4/12/23 at 2:06 p.m., she indicated Resident C had been suicidal and put bags over her head. The Housekeeping Supervisor was informed, on 4/11/23, by the DON not to put plastic bags in her room. She had not told the other housekeepers not to put the bags in the resident's trash can. During an interview with Housekeeper 3 and Unit			

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	Manager 16, on 4/12/23 at 2:08 p.m., the Housekeeper indicated she was not aware Resident C was suicidal and not to put plastic bags in her trash cans until five minutes prior to the interview. Unit Manager 16 indicated on 4/11/23, they found three rolls of plastic bags under Resident C's mattress. During an interview with LPN 24, on 4/12/23 at 2:50 p.m., she indicated Resident C was basically having attention - seeking behaviors. She was upset about wanting a pain pill and had called 911. She continuously said she wanted to go to the hospital and she was going to do something to herself until she succeeded. She was on 15 minute checks. LPN 24 was told in report she had placed a bag over her head. The resident would get mad if her family didn't answer the phone and she would refuse to eat and take medications. During an interview with CNA 11, on 4/12/23 at 3:11 p.m., she indicated all she knew about Resident C was she liked to hoard things. She did not know of anyone, and had not been told of anyone, in the facility with suicidal ideation. She knew she was to check on Resident C every 15 minutes since she had been back from the hospital. During an interview with CNA 17, on 4/12/23 at 3:18 p.m., she indicated that Resident C had been suicidal on 4/11/23. She turned on her call light before supper when they were trying to get everyone to the dining room. She went to her room to answer her call light and she was in the act of putting a plastic trash bag on her head. The ADON removed the trash bags from three of the trash cans that were in her room. They brought her to the TV lounge. She didn't want to go to the dining room to eat so, she ate in her room. She			

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	told the nurse she was in pain and they gave her some medicine. She was on 15 minute checks and they encouraged her to go to activities. On 4/11/23 CNA 17 was told not to put trash bags in her room. During an interview with the ADON, on 4/13/23 at 11:20 a.m., she indicated she talked with Resident C, who said she was in pain and talked about the other residents getting medication. She had no outward signs of pain and she ignored difficult questions. The NP was notified of her complaints of pain and there were no new orders given. Because of her history she knew her, but if was the first time you met her, you may not see it like that. Later in the shift she did place a bag on her head. She was in the facility until 7:00 p.m. but worked as the nurse until 6:00 p.m. She was upset and continued to complain of pain and did not help, so she used the phone and called 911. The NP was made aware and there was an order to send to her to the ER at 10:05 p.m. She had not witnessed her putting a bag on her head and they did remove the bags from her room. She did not document in the nurse's notes when it was reported to her the resident had put a bag over her head. During an interview with QMA 9, on 4/13/23 at 2:27 p.m., she indicated on 4/11/23, Resident C mostly complained of having pain. She told her she could have acetaminophen, but she did not have other orders for pain. She refused to take acetaminophen. She would get upset and frustrated, she said she wanted to go to the hospital and she was going to put bags on her head, so they made sure she didn't have bags in her room. She was on 15 minute checks. She had not witnessed her putting a bag on her head but had seen her grab one. She got upset if she was			

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	unable to get ahold of her family, then she wanted to go to the hospital. She wanted pain medication and refused her medications. She had tried to put a bag on her head many times and would frequently say she would put a bag over her head. QMA 9 had done sweeps of her room before and removed bags from her room. She would hide them in her drawers or under her mattress. QMA 9 found eight rolls of bags in her room before. A 12/2007, revised policy titled, "Suicide Threats," provided by the DON, on 4/13/23 at 3:12 p.m., indicated the following: " ...Policy Statement: Resident suicide threats shall be taken seriously and addressed appropriately. Policy Interpretation and Implementation...5. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately...7. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. 8. Staff shall document details of the situation objectively in the resident's medical record...." B. Resident E's clinical record was reviewed on 4/12/23 at 2:00 p.m. Diagnoses included catatonic schizophrenia, generalized anxiety disorder, type II diabetes mellitus without complications, schizoaffective disorder, bipolar type, essential (primary) hypertension, chronic obstructive pulmonary disease, diabetes mellitus due to underlying condition with diabetic neuropathy, and pain in left arm. His current physician orders included lisinopril (treat blood pressure) 40 mg daily, paliperidone palmitate (antipsychotic) 234 mg/1.5 ml (milliliters)			

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	every 28 days, trazodone (antidepressant) 100 mg daily, buspirone (antianxiety)10 mg twice daily, carvedilol (treat blood pressure) 6.25 mg twice daily, gabapentin (treat neuropathy) 300 mg twice daily, haloperidol (antipsychotic) 5 mg twice daily, tramadol (pain reliever) 50 mg every six hours as needed (4/9/23), and anti-roll back bars on wheelchair (11/9/22). His fall risk assessments, dated 2/22/23 and 4/12/23, indicated he was at a high risk for falls. A quarterly, 3/27/23, MDS (Minimum Data Set) assessment indicated he was cognitively intact. He required limited assistance of one staff member for bed mobility. He required extensive assistance of one staff member for transfers. He required supervision with set up help only for walking in his room, the corridor, and locomotion on the unit. He required supervision of one staff member for locomotion off the unit, dressing and personal hygiene. He required extensive assistance of two staff members for toilet use. He used a wheelchair. He had a current, 6/28/22, care plan for being at risk for falls. His goal was he would not sustain serious injury. His interventions included anticipate and meet his needs (6/28/22), assist with toileting (6/28/22), assist with transfers (6/28/22), he was to utilize foot wear with non-skid soles (6/28/22), he was to utilize a wheel chair with anti-roll back bars on it when outside smoking (8/31/22), and educate him on taking smaller, slower inhalations of his cigarette (9/20/22). Review of nurses notes indicated the following: A late entry nurses note, dated 4/7/23 at 10:13 a.m. and created on 4/12/23 at 10:17 a.m., indicated during routine care he was found to have a			

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(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
	yellow/purple bruise covering his left arm/shoulder/armpit/hand, with swelling noted, and he had very limited ROM (Range of Motion). He complained of pain to the area and was unable to move his arm/hand. He reported he had fallen a couple of days ago. The ADON and the NP were made aware. On 4/7/23 at 7:21 p.m., he complained of pain, and his left arm had dark purple bruising from his armpit to his elbow. He had no ROM in his shoulder or his elbow. He was slightly able to move his fingers. He stated he fell in the dining room a few days ago. He had a history of being a poor historian. The ADON and NP was notified, and a new order was received to send him to the emergency room for an evaluation and treatment. A review of the final report of the emergency physician progress report, dated 4/7/23 at 9:33 p.m., indicated Resident E was brought to the emergency department with complaints of left upper extremity swelling. He stated that he fell a couple days ago and was noted to have a swollen left upper extremity with ecchymoses (discoloration from bruising) from the shoulder to the hand. An impression of an x-ray of his left humerus (upper arm bone) indicated comminuted (broken in at least two places) humerus fractures with mildly displaced fracture fragments and intra-articular (inside the joint) extension. On 4/8/23 at 8:00 a.m., he returned to the facility via ambulance. He had a fracture to his left humerus. He was to follow up with orthopedics in two to three days. A late entry social service note, dated 4/11/23 at 11:21 a.m. and created on 4/12/23 at 11:24 a.m., indicated he reported to a QMA that he fell in his			

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	155400	A. BUILDING 00 B. WING	04/14/2023

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CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

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	room. He reported to the Social Service Director that he fell in the dining room after smoking and reported to the CNA that he fell in the bathroom. He was asked about this and he reported that he just fell. A late entry nurses note, dated 4/11/23 at 11:35 a.m. and created on 4/12/23 at 11:40 a.m., indicated he returned to the facility from an orthopedic appointment with new orders for a referral for a surgery consultation, scheduled for 4/14/23. He was encouraged to wear the sling but most of the times, he refused. During an interview with Resident E, on 4/12/23 at 2:25 p.m., he indicated he fell out of his wheelchair in the dining room. Two men helped him up off the floor. He could not remember when it happened, but thought it was in the afternoon. He sometimes walked, except when he went out to smoke, then staff put him in his wheelchair. During an interview with CNA 7, on 4/12/23 at 3:18 p.m., she indicated a little over a week ago, she thought, on Monday 4/3/23, at the last smoke break after supper, Resident E was outside. He had a lit cigarette in one hand and an unlit cigarette in his other hand. He walked in the door to the dining room and fell. She yelled for CNA 14 to get LPN 16. Resident E was trying to get up and she thought he was holding his left arm. LPN 16 and CNA 14 picked Resident E up off of the floor. During an interview with LPN 16, on 4/13/23 at 8:11 p.m., he indicated he did not have a recollection of Resident E falling on Monday 4/3/23, but he was not saying it didn't happen, he just couldn't recall. He was the only nurse most of the evenings he worked. It got extremely busy with the acuity level, behaviors, and being the			

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	only licensed nurse in the building. The typical procedure was, after a resident fell, he would put a note in the computer, enter the fall into risk management, and then let the ADON know about the fall. During an interview with CNA 14, on 4/13/23 at 8:27 p.m., he indicated on Monday 4/3/23, Resident E got up out of his wheelchair and started running into the building. He bounced off the doorway, stumbled, and fell on his face in the dining room. He went to get LPN 16. LPN 16 did an assessment on him, and together they got Resident E off of the floor. He did not complain of pain that night, but the next day he complained of pain in his left arm. An undated current facility policy titled, "Fall Protocol," and provided by the DON, on 4/13/23 at 3:12 p.m., indicated the following: "...1. Ensure resident safety. 2. Assess resident, check for any injuries, obtain vital signs. 3. Call physician's office...to determine if the resident should be sent to ER and make a progress note with this information. 4. Notify family...5. Complete required documentation: Risk management (includes progress note with description of what happened leading up to the fall) neuro checks if applicable. 6. Text Administrator, DON and ADON...." The immediate jeopardy that began on 4/11/23 was removed on 4/14/23, when the facility educated staff on suicidal threats protocol for the identification and reporting of threats, and the safety of residents with threats of suicide, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because all staff had not yet been educated.			

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	This Federal tag relates to complaint IN00405975. 3.1-45(a)(1)			