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	03/14/2024

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 IN00430255, IN00430035 and IN00430104. Complaint IN00430255 - No deficiencies related to the allegations are cited. Complaint IN00430035 - Federal/State deficiencies related to the allegations are cited at F740 Complaint IN00430104 - Federal/State deficiencies related to the allegations are cited at F740 . Survey dates: March 12, 13 and 14, 2024 Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 5 Medicaid: 56 Other: 7 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 25, 2024.	F 0000	April 3, 2024 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID JZHE11 Dear Ms. Buroker: Please find attached my Plan of Correction for the deficiency 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 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karsen Rauch	HFA - Administrator	04/09/2024

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	must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to identify resident behavioral health needs and failed to develop individualized care plans to address resident behavioral safety for 3 of 3 residents reviewed for resident behavioral health needs (Residents B, C, and D). Findings include: 1. Review of a 3/9/24 facility "Self Reported Incident" indicated the facility found two "needles" in Resident D's room when cleaning. The facility suspected drug use. The police were contacted. The resident was sent to the hospital for a drug screen. Resident D's clinical record was reviewed on 3/12/24 at 11:36 a.m. Current diagnoses included anxiety, major depressive disorder and bipolar disorder. A history of substance abuse was not included on the resident's current diagnoses. The clinical record contained scanned in documents of the resident's history prior to admission. Review of documents related to the resident's hospital stay on 10/3/23 included the following: Diagnoses of cocaine dependence, uncomplicated, methamphetamine abuse,	F 0740	**F740** **1 – Upon notification of deficiency, F740 was reviewed, and the deficiency was discussed with the IDT. The residents' care plans, individualized interventions and behavior plan was reviewed and updated. It is the practice of this facility that if a resident needs Behavioral Health Services, the appropriate treatment and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being is provided. 2 – The facility has determined that all residents with behavioral health needs or a like diagnosis have the potential to be affected. 3 – SSD or designee will complete a house audit of care plans relative to behavioral health needs and/or psych diagnoses. Any resident identified by the audit as lacking and/or needing personalized care plans with behavioral**	04/09/2024

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	episodic, amphetamine-type substance use disorder, bipolar disorder, and patient non-adherence. An "Assessment and Plan" indicated the resident was not permitted to return to his group home due to behavioral issues. A 10/4/23 progress note indicated "has a long history of Bipolar 1 disorder, anxiety, and poly drug use (meth, cocaine in recent history)..." A 2/8/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and daily displayed maladaptive behaviors which were not directed towards others. The clinical record lacked the following: A preadmission assessment to ensure the facility was able to meet the residents needs and provided the resident and others safety regarding a history of illegal drug use, An individualized plan of care which included personalized approaches to ensure the safety of the resident and others related to illegal drug use, Behavior monitoring and management related to multiple substance abuse disorders, and A plan to ensure the resident and other's safety following an event of finding alleged illegal drugs in his room. During an interview on 3/12/24 at 3:34 p.m., the Administrator indicated the facility had begun completing pre admission assessments about one week ago. The facility had not completed a		**interventions and flowsheets will be added, updated, corrected at that time. After any updates are made, necessary staff will be updated and educated.** **The team conducts admission audits for each new admission. As part of that, we will review and update careplans appropriately.** **The SSD or designee will also update careplans as needed for current and future residents. The IDT meets daily and discusses behavioral concerns and careplans are updated as needed. There are also monthly Behavioral Health meetings with Psych NP where any concerns are brought up and careplans are updated as needed too.** **Along with that, an all staff in-service was conducted on 3/27/24 where the concerns discussed during the exit conference were discussed.** **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 on the basis of compliance. 5 –**	

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	preadmission assessment for Resident D prior to his admission. During an interview on 3/13/24 at 10:53 a.m., QMA 99 indicated she was working when syringes were found in the resident's room. They were not formally informed by the facility of any needed behavioral monitoring the resident had due to a history of illegal drug use. She heard of the resident's history through other co-workers. The resident did openly speak of his past history of substance abuse. During an observation and interview on 3/13/24 at 11:43 a.m., the resident was in wheelchair outside dining room and indicated he "felt rough." During an interview on 3/13/24 at 11:49 a.m. the Social Services Assistant (SSA) indicated the staff were not informed at the time of admission of the resident's history of illegal drug use. She was unaware of any plan to keep the resident or others safe from illegal drugs. The resident has had visitors in the facility. During an interview on 3/13/24 at 11:54 a.m., Housekeeper 6 indicated she was cleaning the resident's room when she found a syringe under the resident's bed. The resident was not present, as he was taking a shower at the time. When she found the syringes, she got help right away. She notified the SSD, who obtained the syringes from the resident's room and secured them. During an interview on 3/13/24 at 12:00 p.m., the psychiatric services Nurse Practitioner indicated the facility had not informed her of a past substance abuse history. The resident informed her of his past history of meth and heroin use. He told her he hadn't used in over a year. She had		**Corrective action completed by 4/3/24.**	

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	met with the resident regarding depression. She had not been involved in developing or implementing a safety plan regarding a substance abuse history. During an interview on 3/13/24 at 12:09 p.m., the Social Services Director (SSD) indicated she did not remember if she reviewed the residents paperwork before admission. She did not recall when she had been made aware of his history of substance abuse. She was present when the syringes were found in the resident's room and lead the staff in searching. One syringe was found under his bed. One syringe was found in the closet in his tennis shoe. Both syringes had a dark sticky substance in them. The substance was about the color of iced tea and was thick and sticky. She heard he met someone on line and they came to the facility. The resident told her he received the syringes when "the guy brought them into him." The resident told her the substance in the needle was heroin. She was not a part of developing a plan for him to stay clean, safe, and sober. After the drugs were found in his room, she asked about a safety plan. The Administrator and DON indicated they would develop and direct a safety plan. The police were notified and came and removed the syringes. They indicated to the facility they could not provide any other services or investigation regarding the syringes and substance inside. During an interview on 3/13/24 at 12:35 p.m., the DON indicated she began employment in the facility in December 2023, after the resident had admitted. She did recall a staff member telling her the resident had a history of illegal drug use. Although he told her the substance in the syringe was drugs, she could not be sure if he knew what he was saying because he had cognitive			

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	impairment. There was a liquid inside the syringes they found, and it was a dark, yellowish-brown amber color. The resident could make calls and get on line with his cell phone. The resident could dress himself, and feed himself, make his needs known. He liked to be independent and has had visitors. He had a visitor approximately one day before the syringes were found. During an interview on 3/13/24 at 2:58 p.m. LPN 5 indicated she was on duty when a guest came in between 6:15 a.m. and 6:30 a.m. The guest asked for assistance in finding the resident. She thought the visitor might come to the facility for a more intimate visit and had not been concerned about drug use or purchases. To ensure the dignity of the resident's roommate, she decided to go to the room to remind the resident it was smoking time. She did not see any transaction occur. She was aware the resident had a history of drug abuse. She did not recall where she first heard it, but the resident did tell her himself. The staff did not always know of the resident's behavioral histories or safety concerns upon admission. 2. Review of a 3/7/24 facility "Self Reported Incident" indicated Resident C, who had a diagnosis of dementia, was found in the room and bed of Resident B, who also had a diagnoses of dementia. Both residents were undressed from the waist down. Neither resident appeared to be in distress. Resident C was immediately removed from Resident B's room. Resident C's clinical record was reviewed on 3/12/24 at 11:00 a.m. Current diagnoses included, Alzheimer's disease, dementia, and major depressive disorder.			

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	A 2/21/24, admission, MDS assessment indicated the resident was severely cognitively impaired and wandered 1 to 3 days of the assessment period. Records from a previous nursing home and hospital stay prior to admission were scanned into the resident's record. A 1/19/24, Progress Note from a previous facility indicated the resident had been affectionate with another resident and had kissed him [the remainder of the note was illegible]. A "Medical Progress Notes" from her 1/20/24 hospital stay indicated she had been exhibiting sexually inappropriate behaviors, touching and sitting on male resident's laps. When redirected, the patient had been physically combative with staff. A 1/31/24 at 8:30 p.m., hospital "Nursing Note" indicated the resident placed her hands on a male resident and he began yelling. A 2/15/24, 4:50 p.m., nurses note indicated the resident was admitted to the facility from a sister facility. The resident was wandering in the hallway and dining room. A 2/20/24, Nurse Practitioner visit note indicated, at her previous facility, the resident was wandering into other resident rooms and had been involved in an alleged sexual touching event. A 3/7/24 at 3:25 p.m., nurses note indicated the resident had been found in a male resident's room in his bed and both resident's were undressed from the waist down. The clinical record lacked the following: A preadmission assessment to ensure the facility			

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	was able to meet the residents needs and provided the resident and others safety regarding touching others and sexually inappropriate behaviors, An individualized plan of care regarding the resident's history of sexual inappropriate behaviors which included personalized approaches to ensure the safety of the resident and others, and A behavior monitoring and management plan related to wandering, touching others, and/or sexually inappropriate behaviors. During an observation on 3/12/24 at 1:20 p.m., Resident C was seated in the lounge in a recliner. During observations on 3/13/24 at 10:58 a.m., 11:08 a.m., and 2:50 p.m., the resident was seated in a recliner in the lounge. During an interview on 3/12/24 at 3:34 p.m., the Administrator indicated Resident C was admitted from a sister facility because the previous facility could not meet the resident's behavioral needs. Because the resident had resided at a sister facility prior to admission,the facility did not receive a pre-admission assessment. The goal for the resident had always been to acquire a female only dementia unit. The Administrator had been working "behind the scenes" to locate such a facility since her admission to the facility. There was no documentation or plan regarding the resident's need for a female dementia unit. During a confidential interview, an employee indicated Resident C did wander the halls, took things off carts, and went in and out of other resident's rooms. The resident picked up items			

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	from other resident's rooms. The employee was not aware the resident had a history of touching others. During an interview on 3/13/24 at 11:15 a.m., CNA 8 indicated she had not been informed of Resident C touching others. The resident did wander about and staff had been told she wandered. The resident was able to get out of the lounge recliner on her own. Staff must learn about residents and what they like, and to know resident specific approaches to behaviors. She did not recall being informed of any resident specific approaches for Resident C. During an interview on 3/13/24 at 11:20 a.m., LPN 7 indicated, upon admission, she had been told the resident wandered. She had not been informed the resident touched others. She had not been aware of any safety plan to protect the resident and others from her touching behaviors. She was not aware the resident had a past history of sexually inappropriate behaviors prior to the event withe Resident B. During an interview on 3/13/24 at 11:45 a.m., the Activity Assistant indicated she had found Resident C in Resident B's room, in bed with him. She had been helping direct residents to the dining room for lunch. She saw two sets of feet in Resident B's bed. Both residents were undressed form the waist down. The were laying in bed "spooning" each other. Neither resident appeared to be in distress. She had not been informed Resident C had a past history of sexually inappropriate behaviors. She was unaware of any care plan or staff instructions to keep Resident C from touching others nor to ensure her safety. She sought assistance from the nurse to separate Resident C and B.			

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	During an interview on 3/13/24 at 12:28 p.m., the SSD indicated she had not had access to all of Resident C's previous hospital and nursing home notes prior to her admission. She did not know of the extent of her touching others nor her sexual inappropriate interactions. 3. Resident B's clinical record was reviewed on 3/12/24 at 11:45 a.m. and their current diagnosis included dementia. The resident's clinical record did not indicate he wandered or displayed any sexually inappropriate behaviors. A 3/7/24, 3:32 p.m., "Nurses Note", indicated a female resident was found in bed with the resident. Both residents were undressed from the waist down. The resident did not appear in distress. A 1/7/24, quarterly MDS assessment indicated the resident was severely cognitively impaired and did not display maladaptive behaviors during the assessment period. During an observation on 3/12/24 at 1:20 p.m., the resident was seated in a recliner in his room watching TV. During an observation on 3/13/24 at 11:07 a.m., the resident was napping in bed. During an interview on 3/13/24 at 11:10 a.m., CNA 9 indicated there wasn't a formal system to manage resident behaviors. She had to get to know the residents. When she knew a resident, she would then use what she knew to offer them items and distractions they liked. Until she got to know the resident, she used approaches that have worked for other residents in the past.			

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	A current, undated, facility policy titled "Care Strategies Behavior Management Program", provided by the Administrator on 3/14/24 at 10:18 a.m., indicated, "...establishing a plan of treatment for those residents identified as needing 'Behavior Management'. Behavior/Mood indicators may adversely affect the well-being of the resident, peers, staff, or visitors. Examples may include... wandering and mood indicators...." This citation relates to Complaints IN00430035 and IN00430104.			