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	06/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00411164, IN00410516 and IN00410482. Complaint IN00411164 - No deficiencies related to the allegations are cited. Complaint IN00410516 - Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00410482 - No deficiencies related to the allegations are cited. Survey dates: June 20 and 21, 2023. Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 3 Medicaid: 43 Other: 3 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 27, 2023.	F 0000	July 12, 2023 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID NE3L11 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during this Complaint Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Karsen Rauch, HFA Administrator Cardinal Care Strategies	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karsen Rauch	HFA - Administrator	07/13/2023

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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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observations, interviews, and record reviews, the facility failed to protect the residents' right to be free from physical abuse by Resident B for 2 of 6 residents reviewed for abuse (Residents M and C). Findings include: 1. Resident B's clinical record was reviewed on 6/20/23 at 1:20 p.m. Diagnoses included, alcohol dependence, anxiety disorder, delusional disorders, alcohol use, unspecified with alcohol-induced persisting dementia, psychotic disorder with hallucinations due to known physiological condition, vascular dementia, moderate, with agitation, with other behavioral disturbance, with psychotic disturbance and with mood disturbance. His orders included ziprasidone (antipsychotic) 80 mg (milligram) by mouth two times a day (1/20/23), send to neuropsychiatry for inpatient psychiatric stay (2/21/23), send to behavioral center for evaluation and treatment (3/24/23), one on one supervision to be provided until further notice (5/24/23), buspirone (anxiety) 10 mg three times	F 0600	PROPOSED PLAN OF CORRECTION F600 1 – Upon notification of deficiency, Resident A no longer resides in our facility. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Director of Nursing will educate nursing staff on our current abuse policy and our current behavioral management plan. An in service for nursing staff will be conducted on behaviors and abuse. 4 - The Director of Nursing or nursing management staff will review 5 residents' behavior care plans per week. The reviews will continue weekly for 6 weeks and	07/12/2023

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	daily (6/9/23), resident was physically able to be discharged at this time due to his behaviors which endangered the safety of the other resident (3/10/23). A quarterly MDS (Minimum Data Set), dated 3/18/23, indicated he was severely cognitively impaired. He required extensive assistance of two staff members for transfers. He required extensive assistance of one staff member for walking in his room or the corridor and locomotion on and off the unit. He did not use an assistive device for ambulation. He had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) that occurred four to six days during the assessment period. He wandered one to three days of the assessment period. He had a current care plan for exhibiting physical and verbal aggression towards a peer (12/6/21). His goal was he would not show behaviors of physical and/or verbal aggression towards a peer through next review. His interventions included the following: Assess for pain and toileting needs (12/30/21). A door alarm was placed on his door to alert when he exited or when others attempted to enter his room, he removed the alarm (2/14/23). Explain to him his behavior was inappropriate (12/30/21). Talk to him about the feelings and rights of others who are exposed to negative behavior (12/30/21). Initiate 15-minute checks (2/5/23). Keep other residents from entering his room (2/5/23). Stop sign placed on his door to deter other peers from entering his room (2/13/23). He had a care plan for potential psychosocial distress related to an altercation with a peer (initiated on 5/25/22, and updated on 5/21/23). His		until compliance is maintained. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 7/12/23	

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	goal was he would not show signs or symptoms of psychosocial distress related to the incident. His interventions included to encourage him to participate in activities of interest such as, music, coffee and talking with his daughters (5/25/22) and provide one to one supervision (5/21/23). A nurses note, dated 5/21/23 at 9:22 p.m., indicated at approximated 8:15 p.m., the nurse was called to the (secured) dementia unit. Resident B came out of his room unprovoked and struck Resident M in the head. No injuries were noted or reported on either resident. He then went directly back into his room. One on one supervision was put in place until the police arrived. The psychiatric nurse practitioner (NP) was made aware and a new order was received to send him to the ED. At 8:45 p.m. the EMTs and the police arrived. Staff attempted to get him onto the stretcher, and he indicated he was not going anywhere and got up from his bed and walked towards the EMT. He was then asked if he was going to get on the stretcher assisted or unassisted. He indicated again he was not going anywhere. After three attempts, the police officer told him they had to go and asked if he would like the stretcher brought in, or would he walk to the stretcher, he got up and started to advance towards the door and at the police officer. The police officer and his partner attempted to keep him from leaving, and he pulled his arm away and started cussing at them. He then advanced on the other police officer and became very agitated and aggressive. He tried to pull up his arm and swing, and he was restrained by the police officers and continued to cuss and struggle/fight with them until they brought handcuffs out . They were able to safely and securely get him handcuffed and lowered him onto the stretcher. Once on the stretcher, he was able to have the handcuffs			

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	switched out and be cuffed separately to the stretcher. He kicked at staff and yelled until they were able to get the safety belts on and secured. They took him out via stretcher to the hospital. The DON, ADON, and on-call nurse were made aware. A review of an emergency department (ED) physician progress note, dated 5/21/23 at 9:10 a.m. indicated he had aggression, he was very agitated and violent and he required to be temporarily hand-cuffed to the side-rail during the EMS transport. He was seen on 12/6/22 and 3/20/23 for the same complaint. His daughter reported he often sundowned and could become aggressive, but then typically, he calmed down by himself and he could not remember or recalled his behavior. Resident M's clinical record was reviewed on 6/21/23 at 1:51 p.m. Diagnoses included, major depressive disorder, recurrent, unspecified dementia, severe, with agitation, psychotic disturbance and anxiety, anxiety disorder due to known physiological condition, generalized anxiety disorder, restlessness and agitation. An admission MDS, dated 5/3/23, indicated she was severely cognitively impaired. She required supervision for walking in her room and in the corridor and locomotion on and off the unit. She did not use an assistive device for ambulation. She wandered daily during the assessment period. She had a care plan for being placed on locked unit due to her long mental health history with physical aggression, in patient psychiatric stays, and exit seeking. She was to be on the unit and assessed at later date to see if adjusting well and will move off unit when deemed appropriate (4/27/23).			

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	A nurses note, dated 5/21/23 at 9:45 p.m., indicated the nurse was notified of the incident regarding an altercation from Resident B. After the situation, she was assessed and she had no signs of pain or distress. Neurological checks were started. A review of the facility investigation of the altercation with Resident B and Resident M, included a handwritten statement by QMA 5. The QMA was in the middle of the medication pass when Resident B came out of his room, walked up to Resident M, and hit her in the head. Resident M yelled and asked why Resident B did that. Resident B indicated he did not hit Resident M. QMA 5 told the resident he had hit Resident M and it was wrong and not nice. Resident B did not reply and went back to his room. 2. On 6/9/23 at 5:30 p.m., Resident B was in the hall sitting next to Resident C. He was agitated and exhibited (unspecified) behaviors. Redirection was given, which caused more agitation. He stood up and hit Resident C in the chest. They were immediately separated. Resident B was on one to one supervision. The NP was called and a new order was received to send him to the ED and to call the police. Resident B's family was notified. EMS arrived at the facility, but was unable to transport him to the ED because he answered four of five screening questions and it would be kidnapping. The EMT's supervisor was requested and they awaited the police to arrive at the facility to speak to the resident. An application for emergency detention of mentally ill person, dated 6/9/23 at 6:55 p.m., indicated Resident B was suffering from physical aggression. He was dangerous to himself and			

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	others because he assaulted another resident unprovoked. He had a history of unprovoked physical aggression towards other residents. It was believed if Resident B was not restrained immediately, he would assault another resident. On 6/9/23 at 8:14 p.m., a new order was received from the medical director to send Resident B to the ED for a 72-hour hold due to increased physical aggression towards Resident C. Resident B left via stretcher by ambulance and was cooperative. His family was made aware, who voiced concerns about the police escort and was instructed, due to his previous history, it was in the best interest for him and the staffs' safety. Review of an ED physician progress note, dated 6/9/23 at 9:33 p.m., indicated Resident B had hit another resident and was in the process of being evicted from the facility. He needed placement. He had 13 attacks on other residents in one year. Resident C's clinical record was reviewed on 6/20/23 at 2:12 p.m. Diagnoses included schizophrenia, depression, attention and concentration deficit, and mild cognitive impairment of uncertain or unknown etiology. A quarterly MDS, dated 5/20/23, indicated he was moderately cognitively impaired. He required extensive assistance of one staff member for transfers. He required supervision for locomotion on and off the unit. He used a wheelchair. He had verbal behaviors (e.g., threatening others, screaming at others and cursing at others) one to three days during the assessment period. His medications included donepezil hydrochloride (memory loss) 5 mg daily, haloperidol decanoate (schizophrenia) intramuscular solution, inject 50			

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	mg intramuscularly once every 30 days, escitalopram oxalate (depression) 10 mg daily, memantine (memory loss) 5 mg daily and olanzapine (schizophrenia) 20 mg daily. He had a care plan for a peer to peer altercation (6/12/23). His goal was he would no exhibit behaviors of peer to peer altercation through next review. His interventions included the following: Initiate 15 minute checks, as needed (6/12/23). Provide comfort and reassurance, as needed (6/12/23). Remove him from the situation (6/12/23). Separate the residents immediately (6/12/23). A nurses note, dated 6/12/23 at 4:40 p.m., indicated Social Service met with him to follow-up on his psychosocial well-being related to an incident with a peer. He was able to recall the behavior and reported the guy hit him right in the chest and the cops came. He was allowed to express his feelings and comfort and reassurance was provided. His care plan was reviewed and revised, as needed. Social Service was to provide one on one visits, as needed. During an interview with Resident C, on 6/20/23 at 3:24 p.m., he indicated he was talking to the employees and asked them if they could smoke for a half hour and smoke four cigarettes. Resident B told him not to talk about stuff like that, and hit him with his fist in the middle of his chest and it hurt awful. He called him some names after he had hit him. He did not hit him back. Resident B was a bully, he bullied the staff and other residents. He was gone now and he did not want him to come back. During an interview with the Administrator, on 6/21/23 at 9:30 a.m., she indicated Resident B and C had words with each other. Resident B was			

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	known to hit people and he hit Resident C in the chest. This was the second time in a month Resident B had an altercation with another resident. The EMS and the police department was called. The EMTs would not take Resident B until a 72 hour hold order was received. The Social Worker at the hospital indicated he was not having any behaviors and he did not qualify for a psychiatric inpatient stay. The Administrator tried to explain to her his behaviors, he would be calm and then have outbursts. The Administrator read notes from the hospital that indicated they had to give him an Ativan (antianxiety) injection when he first arrived at the hospital due to aggressive behaviors and irritation, but they told her, he was not having behaviors. He moved so quickly and they could not stop him, even if he was on one to ones. During an interview with QMA 16, on 6/21/23 at 10:19 a.m., she indicated she heard Resident B and Resident C telling each other to calm down. The next thing she knew, Resident C was holding his chest. They were sitting next to each other, in facility chairs, across from the nurses station. The CNA was sitting with Resident B because he was on one to ones. Resident B had an outburst about a month ago. They separated Resident B and Resident C, and let the nurse know. During an interview with CNA 12, on 6/21/23 at 2:00 p.m., she indicated she had been doing one to ones with Resident B while he was in the dining room. He went to his room and then came out of his room and sat beside Resident C across from the nurses station. Resident C was already agitated, and she tried to redirect him. His agitation started to become irritating to Resident B, and a "switch flipped". She did not hear the beginning the conversation, as she was down the			

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	hallway towards the dining room helping another resident. She was not sure where the QMA was. Resident C called Resident B a name, and then Resident B called him a name. As she was going towards them, Resident B started to swing at Resident C. Resident B yelled and got agitated super easy. Most of the time he was okay, until another resident had a behavior and then would act out. Resident M was very quiet. She liked to walk into resident's rooms and she needed redirection. During an interview with LPN 9, on 6/21/23 at 2:42 p.m., she indicated she did not see anything regarding Resident B and C. The QMA reported to her they were sitting next to each other and some words were exchanged. Resident B stood up and hit Resident C in the chest. He was on one to ones, and it happened so quickly they couldn't prevent it. The psychiatric NP was called and told her to send Resident B out. The EMTs refused to take the Resident B because he answered three of four questions appropriately and it would be kidnapping if they took him. She left before the EMTs took Resident B. Resident C was a very sweet guy and kept to himself. He became agitated easily. If someone was yelling, he got angry and would cuss at the other resident. A current, undated policy, titled "Abuse and Prevention Policy," provided by the Administrator, on 6/21/23 at 9:14 a.m., indicated the following: "Policy: This facility shall observe the resident's right to remain free from...physical abuse...." This Federal tag relates to complaint IN00410516. 3.1-27(a)(1)			