STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	î í	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
THE PLANT		155400	B. WI				01/03/2024	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD JACKSON ST			
CARDIN	AL CARE STRATE	GIES		MUNCI	E, 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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
F 0000	REGUENTORT	KESC ISENTI TING IN ORGANITO		1710			DITE	
Bldg. 00	IN00424046 and IN Complaint IN00424 the allegations are of Complaint IN00424 related to the allegation and F610.  Survey dates: Januar Facility number: 1002 Facility number: 1002 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type Medicare: 6 Medicaid: 54 Other: 6 Total: 66 These deficiencies accordance with 41	4046 - No deficiencies related to cited.  4700 - Federal/State deficiencies ations are cited at F602, F609  ary 2 and 3, 2024.  20269 255400 267720	F 00	000	January 22, 2024  Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204  Re: Survey Event ID RPY71  Dear Ms. Buroker:  Please find attached my Plar Correction for deficiencies ci during this Complaint Survey am respectfully requesting pa compliance.  If you have any questions, pl feel free to contact me.  Sincerely,  Karsen Rauch, HFA Administrator Cardinal Care Strategies	n of ted 7. I aper		
F 0602 SS=D Bldg. 00	§483.12 The resident has abuse, neglect, m	ropriation/Exploitation the right to be free from isappropriation of resident loitation as defined in this						

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

(X6) DATE

TITLE

Karsen Rauch HFA - Administrator 01/22/2024

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 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155400	B. W	B. WING 01/03/2024			/2024
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			JACKSON ST		
CARDINI	AL CARE STRATE	GIES			E, IN 47303		
CARDIN	-L OANL STRATE	OILO	_	MONCI	L, IIV 47 000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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
	subpart. This incl	ludes but is not limited to					
	freedom from corp	poral punishment,					
	involuntary seclus	sion and any physical or					
	chemical restraint	not required to treat the					
	resident's medical	l symptoms.					
		and record review, the facility	F 0	502	PROPOSED PLAN OF		01/22/2024
	•	e theft of resident's property			CORRECTION		
		(QMA 14) for 1 of 5 residents					
	reviewed for abuse.	. (Resident C)			F602		
	Findings include:				1 – Upon notification of deficie	ency,	
					Administrator reviewed finding	-	
	Resident C's clinica	al record was reviewed on		and comprehended the		•	
	1/2/24 at 11:10 a.m	. Diagnoses included major			outlined in the 2567. The		
		, single episode, severe with			administrator reviewed the state		
		hemiplegia and hemiparesis			guidance on the Free from		
		ied cerebrovascular disease			Misappropriation/Exploitation		
		ominant side, aphasia			regulations outlined in the		
		ied cerebrovascular disease			reporting guidelines. A "Free f	rom	
	and generalized any				Misappropriation of Property"		
		•			in-service was added to the		
	A quarterly Minimu	um Data Set (MDS), dated			All-Staff Inservice scheduled for		
		she was cognitively intact.			1/31/24.		
	During an interview	v with Resident C, on 1/2/24 at			2 The facility has determined	d	
	_	cated she didn't realize she had			2 – The facility has determined that all residents have the		
	_	from a hook that was attached			potential to be affected.		
		notorized wheelchair. The wallet			potential to be affected.		
		, but the money was missing.			3 – The Administrator/Nurse		
	· ·	urned to her a week later. She				7	
	<u> </u>	close how much money was in			Managers will educate nursing staff on our current abuse poli		
	the wallet.	close now much money was in			and reporting guidelines for th	•	
	ine wanet.						
	During an interview	w with the Administrator on			facility. An in service will be he	5IU	
	During an interview with the Administrator, on				to go over these policies and touch specifically on the reside	onto'	
	1/2/24 at 2:49 p.m., she indicated Resident C hadn't realized she dropped her wallet. The wallet was					CIII S	
		ck to Resident C. Resident C			right to be free from	ort.	
	1				misappropriation of their prope	əιιy.	
		00 was missing from her wallet			4 The Administrator and/or h	luroc	
		The Administrator watched the			4 - The Administrator and/or N	urse	
	i camera and saw QN	MA 14 pick up the wallet. She	1		Management will take every		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> CO			COMPL	COMPLETED	
155400		B. WING 01/03/2024			/2024			
		<u>I</u>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	₹			JACKSON ST			
CARDINI	AL CARE STRATE	CIES			E, IN 47303			
CARDIN	-L OANL STRATE	OILO		MONCH	L, IIV 47 000			
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ous" with the wallet. They			allegation of stolen property			
		d she admitted to taking the			seriously and make sure a rep			
		ployment was terminated. The			of concern is filled out. If the it	em		
		ght she was aware of the			isn't found quickly, then an			
	·	y 12/4/23, and the money was			investigation/report (within 24			
		t C on 12/5/23. She wasn't			hours) will be started, especia	-		
	1 ~	lates, and did not have a soft			the resident believed the item			
	file on the incident.				stolen. The investigation chec	KIIST		
	Duning a graiteter.	wwith the IID Coordinates			will also be followed once the	:11		
	_	w with the HR Coordinator, on she indicated she was made			report has been made. This w continue for 6 weeks or until	III		
		g money on 12/7/23. QMA 14			compliance is maintained.			
		order in the facility mailbox on			· · · · · · · · · · · · · · · · · · ·	100		
	Monday, 12/11/23	-		As a means of quality assurance,				
	Wioliday, 12/11/23	101 \$730.00.		results of the reviews and any corrective actions taken shall be				
	During an interview	v with LPN 17, on 1/3/24 at						
	_	icated over the weekend of		reviewed by the Quality Assurance Committee for a minimum of six				
		3, Resident C indicated to her			(6) months, with frequency of			
		r wallet somewhere on the 200			monitoring increased or decre	ased		
		d for it and couldn't find it.			on the basis of compliance.	aooa		
		there was a wallet at the			on the basis of compilation.			
		gave the wallet to Resident C.			5 – Corrective action complete	ed by		
		ater, Resident C came back to			1/22/24.	,		
	LPN 17 and indicat	ted \$700.00 was missing from						
		dent happened after lunch, but						
	before second shift.	LPN 17 reported the incident						
	to the ADON, who	was working second shift that						
	day.							
	During an interview	with QMA 14, on 1/3/24 at						
	1 -	icated she had a bill that was						
	due. She took, and then replaced, Resident C's							
	money. She saw Resident C's wallet on the floor,							
	she picked it up, took the money from it and							
	placed the wallet on the treatment cart at the							
		ident C was looking for the						
		her the wallet off the						
		dent C noticed the same day						
		sing from her wallet. The HR						
	Coordinator called her and asked her if she could		1					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY  COMPLETED  01/03/2024		
NAME OF PROVIDER OR SUPPLIER  CARDINAL CARE STRATEGIES		STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	come into the facility on Friday to talk, but then called her back and did a phone interview with her. She admitted to taking the money. She got a loan and returned the money via money order for \$730.00. She put the money order in the facility mailbox.  During an interview with the Administrator, on					
	1/3/24 at 11:56 a.m., she indicated she followed the Indiana Department of Health Policy and Procedure, titled "Long-Term Care Abuse and Incident Reporting Policy," with the effective dates of 12/8/22 - 12/8/23. Review of the policy indicated the following: "Definitions9 Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent"					
	This citation relates to complaint IN00424700.  3.1-28(a)					
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged					
	violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPLETED	
155400			B. WING 01/03/2024				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					JACKSON ST		
CARDIN	AL CARE STRATE	GIES	<u> </u>	MUNCI	E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		involve abuse and do not					
		oodily injury, to the ne facility and to other					
		to the State Survey					
	,	protective services where					
		s for jurisdiction in long-term					
	· ·	accordance with State law					
	through establish						
	-						
	§483.12(c)(4) Re	port the results of all					
	_	he administrator or his or					
	_	presentative and to other					
		ance with State law,					
	•	tate Survey Agency, within					
		the incident, and if the					
	_	s verified appropriate					
	corrective action	and record review, the facility	F 060	0	PROPOSED PLAN OF		01/22/2024
		misappropriation/theft of	F 000	9	CORRECTION		01/22/2024
	_	by a staff member (QMA 14) to			CORRECTION		
		nd law enforcement in the			F609		
		e for 1 of 5 residents reviewed			1.000		
	for abuse. (Resider				1 – Upon notification of deficiency,		
	,				Administrator reviewed finding		
	Findings include:				and comprehended the conce	rns	
					outlined in the 2567 with repo	rting	
		al record was reviewed on			accurate information.		
		n. Diagnoses included major			Administrator updated a writte		
	_	, single episode, severe with			procedure for investigating ab	use,	
	psychotic features, hemiplegia and hemiparesis				neglect, exploitation, or		
		ied cerebrovascular disease			mistreatment. Also, an abuse		
	affecting left non-dominant side, aphasia				allegation and reporting in-se		
	following unspecified cerebrovascular disease				will be conducted in the All-St		
	and generalized anxiety disorder.				Inservice scheduled for 1/31/2 This in-service is already included		
	A quarterly Minim	um Data Set (MDS), dated			in monthly in-servicing and is		
		she was cognitively intact.			touched on regularly in person		
	11/3/23, maicated	mas cognitively muct.			through online in-servicing on		
	During an interview	w with Resident C, on 1/2/24 at			Relias platform.	-41	
	_	cated she didn't realize she had					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
155400		B. WING 01/03/2024				2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			JACKSON ST		
CARDINA	AL CARE STRATE	GIES			E, IN 47303		
					_, <b></b>	ı	
(X4) ID		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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
		from a hook that was attached			2 – The facility has determined	d	
		otorized wheelchair. The wallet			that all residents have the		
		, but the money was missing.			potential to be affected.		
		arned to her a week later. She					
		lose how much money was in			3 – The Management team wi		
	the wallet.				educate all staff on the Abuse		
					Investigation Procedure. The		
	-	with the Administrator, on			Administrator will communicat		
	_	she indicated Resident C hadn't			the findings of the 2567 to the		
	* *	d her wallet. The wallet was			management staff and elabora	ate	
	-	ck to Resident C. Resident C			on the parts of the Abuse		
		00 was missing from her wallet			Investigation Procedure that c	an	
	•	The facility watched the camera			help with ensuring accurate		
		ick up the wallet. She acted			reporting and internal		
	-	wallet. They called QMA 14,			documentation.		
		ng the money, and her					
		rminated. The Administrator			4 – Any and all allegations of		
	-	are of the incident on			abuse will be investigated per	the	
		nd the money was returned to			regulation guidelines. The		
		23. She wasn't positive about	Administrator will conduct an audit				
		ot have a soft file on the			for each investigation and mal		
		t report the incident to the	sure all steps are being followed.			ed.	
	~ .	v enforcement. She felt since it		The Administrator will take all			
	_	quickly, the money was			pieces of the allegations and		
	· ·	an isolated incident, it didn't			report them to the state. Beyo	nd	
	need to be reported.				that, The Administrator will		
	D	Maria Artista de 199			accurately follow up with the s	tate	
	-	with the Administrator, with			and make sure all details are		
		ees (HR) Coordinator present,			included in the report, from the	9	
	-	m., the Administrator indicated			investigation findings.		
		e the police because the			As a means of quality assurar		
		t and dry". QMA 14 returned			results of the reviews and any		
		ay, was very remorseful, and it			corrective actions taken shall		
		r for her. Resident C had			reviewed by the Quality Assur		
	indicated she did no	ot want to press charges.			Committee for a minimum of s	SIX	
		11 0161 14 1676			(6) months, with frequency of		
	_	with QMA 14, on 1/3/24 at			monitoring increased or decre	ased	
	•	cated she had a bill that was			based on compliance.		
		then replaced, Resident C's					
	money. She saw Resident C's wallet on the floor,				5 – Corrective action complete	ed by	

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 01/03/2024				
NAME OF P	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD			
				JACKSON ST			
CARDINA	AL CARE STRATE	GIES	MUNCI	E, IN 47303			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		ok the money from it and		1/22/24.			
	-	n the treatment cart at the					
		ident C was looking for the					
	_	e her the wallet off the					
		ident C noticed the same day ssing from her wallet. The HR					
	-	her and asked her if she could					
		ity on Friday to talk, but then					
		did a phone interview with					
		o taking the money. She got a					
		he money via money order for					
		ne money order in the facility					
	mailbox.	, , , , , , , , , , , , , , , , , , ,					
	During an interview	w with the Administrator, on					
	1/3/24 at 11:56 a.m	., she indicated she followed the					
	Indiana Departmen	t of Health Policy and					
	Procedure, titled "L	Long-Term Care Abuse and					
		Policy," with the effective					
		2/8/23. She provided the policy,					
		following: "Ensure that all					
	-	nvolvingmisappropriation of					
		are reported immediately, but					
		nours after the allegation is					
		that cause the allegation					
		sult in bodily injury, or not if the events that cause the					
		ivolve abuse and do not result					
	-	the administrator of the facility					
		ls (including to the State					
		adult protective services					
		ovides jurisdiction in long term					
	-	ecordance with state law					
	through established						
	-						
	This citation relates	s to complaint IN00424700.					
	3.1-28(c)						
			1	l			

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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 01/03/2024					
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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
F 0610 SS=D Bldg. 00	§483.12(c) In respanses, neglect, exthe facility must:  §483.12(c)(2) Haviolations are thore §483.12(c)(3) Preneglect, exploitation the investigation is  §483.12(c)(4) Repinvestigations to the investigations to the designated reposition of the designated repositions in accordation in accordation in the second including to the St 5 working days of alleged violation is corrective action in Based on interview failed thoroughly in of resident's propert for 1 of 5 residents; C)  Findings include:  Resident C's clinica 1/2/24 at 11:10 a.m. depressive disorder, psychotic features, I following unspecificant generalized anxional accordance of the second control	port the results of all the administrator or his or presentative and to other ance with State law, atte Survey Agency, within the incident, and if the severified appropriate must be taken. and record review, the facility evestigate the misappropriation by by a staff member (QMA 14) reviewed for abuse. (Resident of Diagnoses included major single episode, severe with memiplegia and hemiparesis ed cerebrovascular disease ominant side, aphasia ed cerebrovascular disease	F 0610	PROPOSED PLAN OF CORRECTION  F610  1 – Upon notification of deficie a written procedure for investigating abuse, neglect, exploitation, or mistreatment v reviewed and updated as nee That procedure was communicated to all parties w would be involved in the investigation process. Also, a abuse allegation and reporting in-service will be conducted in All-Staff Inservice scheduled in 1/31/24. This in-service is alre included in monthly in-servicir	vas ded. ho n g the for eady				

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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 01/03/2024 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 and is touched on regularly in The clinical record lacked documentation of the person and through online misappropriation/theft of Resident C's money. in-servicing on our Relias platform. During an interview with Resident C, on 1/2/24 at 2 – The facility has determined 2:32 p.m., she indicated she didn't realize she had that all residents have the dropped her wallet from a hook that was attached potential to be affected. to the side of her motorized wheelchair. The wallet was returned to her, but the money was missing. 3 – The Management team will The money was returned to her a week later. She educate staff on abuse policy. The did not want to disclose how much money was in Administrator will communicate the wallet. the updated investigation procedure to all involved parties. During an interview with the Administrator, on 1/2/24 at 2:49 p.m., she indicated Resident C hadn't 4 – Any and all allegations of realized she dropped her wallet. The wallet was abuse/neglect/exploitation/mistrea found and given back to Resident C. Resident C tment will be investigated per the wasn't aware \$700.00 was missing from her wallet regulation guidelines and the until the next day. The facility watched the camera investigations will be documented. and saw QMA 14 pick up the wallet. She acted The Administrator will conduct an suspicious with the wallet. They called QMA 14, audit for each investigation and she admitted to taking the money, and her make sure all steps are being employment was terminated. The Administrator followed. The Administrator will thought she was aware of the incident on keep records of each step of the Monday 12/4/23, and the money was returned to investigation and will continue to Resident C on 12/5/23. She wasn't positive about audit each party involved for 6 the dates and did not have a soft file on the weeks and until compliance is incident. She didn't report the incident to the maintained. State Agency or law enforcement. She felt since it As a means of quality assurance, was figured out so quickly, the money was results of the reviews and any returned, and it was an isolated incident, it didn't corrective actions taken shall be need to be reported. reviewed by the Quality Assurance Committee for a minimum of six An undated facility checklist, titled "Abuse (6) months, with frequency of monitoring increased or decreased Investigation Checklist," provided by the Administrator, on 1/3/24 at 4:17 p.m., she based on compliance. indicated, at this time, she followed the facility's form for all investigations. The checklist indicated 5 - Corrective action completed by the following: "...Upon notification, 1/22/2024. Administrator/Department Manager will

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

PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFY		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155400	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/03/2024		
NAME OF PROVIDER OR SUPPLIER  CARDINAL CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF immediately susper employee will rema investigation is con completed for resid skin assessment. M documentedInterv allegation. Docume Staff interviews fro hall/area on alleged written statements of resident interviews hall who received of Also interview resid seen/heard alleged in IDOH. Social Servi medical record for of psychosocial suppo	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Id alleged employee. Alleged		MUNCII ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	the investigation fir This citation relates 3.1-28(d)	ndings" to complaint IN00424700.						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RPY711 Facility ID: 000269 If continuation sheet Page 10 of 10