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	01/03/2024

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 IN00424046 and IN00424700. Complaint IN00424046 - No deficiencies related to the allegations are cited. Complaint IN00424700 - Federal/State deficiencies related to the allegations are cited at F602, F609 and F610. Survey dates: January 2 and 3, 2024. Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 6 Medicaid: 54 Other: 6 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 8, 2024.	F 0000	January 22, 2024 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID RPY711 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 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karsen Rauch	HFA - Administrator	01/22/2024

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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	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. Based on interview and record review, the facility failed to prevent the theft of resident's property by a staff member (QMA 14) for 1 of 5 residents reviewed for abuse. (Resident C) Findings include: Resident C's clinical record was reviewed on 1/2/24 at 11:10 a.m. Diagnoses included major depressive disorder, single episode, severe with psychotic features, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, aphasia following unspecified cerebrovascular disease and generalized anxiety disorder. A quarterly Minimum Data Set (MDS), dated 11/5/23, indicated she was cognitively intact. During an interview with Resident C, on 1/2/24 at 2:32 p.m., she indicated she didn't realize she had dropped her wallet from a hook that was attached to the side of her motorized wheelchair. The wallet was returned to her, but the money was missing. The money was returned to her a week later. She did not want to disclose how much money was in the wallet. During an interview with the Administrator, on 1/2/24 at 2:49 p.m., she indicated Resident C hadn't realized she dropped her wallet. The wallet was found and given back to Resident C. Resident C wasn't aware $700.00 was missing from her wallet until the next day. The Administrator watched the camera and saw QMA 14 pick up the wallet. She	F 0602	PROPOSED PLAN OF CORRECTION F602 1 – Upon notification of deficiency, Administrator reviewed findings and comprehended the concerns outlined in the 2567. The administrator reviewed the state guidance on the Free from Misappropriation/Exploitation regulations outlined in the reporting guidelines. A “Free from Misappropriation of Property” in-service was added to the All-Staff Inservice scheduled for 1/31/24. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Nurse Managers will educate nursing staff on our current abuse policy and reporting guidelines for the facility. An in service will be held to go over these policies and touch specifically on the residents’ right to be free from misappropriation of their property. 4 - The Administrator and/or Nurse Management will take every	01/22/2024

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	was acting "suspicious" with the wallet. They called QMA 14, and she admitted to taking the money, and her employment was terminated. The Administrator thought she was aware of the incident on Monday 12/4/23, and the money was returned to Resident C on 12/5/23. She wasn't positive about the dates, and did not have a soft file on the incident. During an interview with the HR Coordinator, on 1/3/24 at 9:15 a.m., she indicated she was made aware of the missing money on 12/7/23. QMA 14 left a blank money order in the facility mailbox on Monday, 12/11/23 for $730.00. During an interview with LPN 17, on 1/3/24 at 11:17 a.m., she indicated over the weekend of 12/2/23 and 12/3/23, Resident C indicated to her she had dropped her wallet somewhere on the 200 hall. LPN 17 looked for it and couldn't find it. QMA 14 indicated there was a wallet at the nurse's station and gave the wallet to Resident C. About 10 minutes later, Resident C came back to LPN 17 and indicated $700.00 was missing from her wallet. The incident 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 12:01 p.m., she indicated 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 nurse's station. Resident C was looking for the wallet and she gave her the wallet off the treatment cart. Resident C noticed the same day her money was missing from her wallet. The HR Coordinator called her and asked her if she could		allegation of stolen property seriously and make sure a report of concern is filled out. If the item isn't found quickly, then an investigation/report (within 24 hours) will be started, especially if the resident believed the item was stolen. The investigation checklist will also be followed once the report has been made. This will continue for 6 weeks or 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 1/22/24.	

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	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: "...Definitions...9... 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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	allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report the misappropriation/theft of resident's property by a staff member (QMA 14) to the State Agency and law enforcement in the required time frame for 1 of 5 residents reviewed for abuse. (Resident C) Findings include: Resident C's clinical record was reviewed on 1/2/24 at 11:10 a.m. Diagnoses included major depressive disorder, single episode, severe with psychotic features, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, aphasia following unspecified cerebrovascular disease and generalized anxiety disorder. A quarterly Minimum Data Set (MDS), dated 11/5/23, indicated she was cognitively intact. During an interview with Resident C, on 1/2/24 at 2:32 p.m., she indicated she didn't realize she had	F 0609	PROPOSED PLAN OF CORRECTION F609 1 – Upon notification of deficiency, Administrator reviewed findings and comprehended the concerns outlined in the 2567 with reporting accurate information. Administrator updated a written procedure for investigating abuse, neglect, exploitation, or mistreatment. Also, an abuse allegation and reporting in-service will be conducted in the All-Staff Inservice scheduled for 1/31/24. This in-service is already included in monthly in-servicing and is touched on regularly in person and through online in-servicing on our Relias platform.	01/22/2024

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	dropped her wallet from a hook that was attached to the side of her motorized wheelchair. The wallet was returned to her, but the money was missing. The money was returned to her a week later. She did not want to disclose how much money was in the wallet. During an interview with the Administrator, on 1/2/24 at 2:49 p.m., she indicated Resident C hadn't realized she dropped her wallet. The wallet was found and given back to Resident C. Resident C wasn't aware $700.00 was missing from her wallet until the next day. The facility watched the camera and saw QMA 14 pick up the wallet. She acted suspicious with the wallet. They called QMA 14, she admitted to taking the money, and her employment was terminated. The Administrator thought she was aware of the incident on Monday 12/4/23, and the money was returned to Resident C on 12/5/23. She wasn't positive about the dates and did not have a soft file on the incident. She didn't report the incident to the State Agency or law enforcement. She felt since it was figured out so quickly, the money was returned, and it was an isolated incident, it didn't need to be reported. During an interview with the Administrator, with the Human Resources (HR) Coordinator present, on 1/2/24 at 3:24 p.m., the Administrator indicated they did not involve the police because the incident was so "cut and dry". QMA 14 returned the money right away, was very remorseful, and it was out of character for her. Resident C had indicated she did not want to press charges. During an interview with QMA 14, on 1/3/24 at 12:01 p.m., she indicated 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,		2 – The facility has determined that all residents have the potential to be affected. 3 – The Management team will educate all staff on the Abuse Investigation Procedure. The Administrator will communicate the findings of the 2567 to the management staff and elaborate on the parts of the Abuse Investigation Procedure that can help with ensuring accurate reporting and internal documentation. 4 – Any and all allegations of abuse will be investigated per the regulation guidelines. The Administrator will conduct an audit for each investigation and make sure all steps are being followed. The Administrator will take all pieces of the allegations and report them to the state. Beyond that, The Administrator will accurately follow up with the state and make sure all details are included in the report, from the investigation findings. 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 based on compliance. 5 – Corrective action completed by	

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	she picked it up, took the money from it and placed the wallet on the treatment cart at the nurse's station. Resident C was looking for the wallet and she gave her the wallet off the treatment cart. Resident C noticed the same day her money was missing from her wallet. The HR Coordinator called her and asked her if she could 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. She provided the policy, and it indicated the following: "...Ensure that all alleged violations involving ...misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long term care facilities) in accordance with state law through established procedures...." This citation relates to complaint IN00424700. 3.1-28(c)		1/22/24.	

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F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed thoroughly investigate the misappropriation of resident's property by a staff member (QMA 14) for 1 of 5 residents reviewed for abuse. (Resident C) Findings include: Resident C's clinical record was reviewed on 1/2/24 at 11:10 a.m. Diagnoses included major depressive disorder, single episode, severe with psychotic features, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, aphasia following unspecified cerebrovascular disease and generalized anxiety disorder. A quarterly Minimum Data Set (MDS), dated 11/5/23, indicated she was cognitively intact.	F 0610	PROPOSED PLAN OF CORRECTION F610 1 – Upon notification of deficiency, a written procedure for investigating abuse, neglect, exploitation, or mistreatment was reviewed and updated as needed. That procedure was communicated to all parties who would be involved in the investigation process. Also, an abuse allegation and reporting in-service will be conducted in the All-Staff Inservice scheduled for 1/31/24. This in-service is already included in monthly in-servicing	01/22/2024

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

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	immediately suspend alleged employee. Alleged employee will remain suspended until investigation is complete. Nurses note will be completed for resident regarding incident with skin assessment. MD/NP and Family notification documented...Interview resident involved in allegation. Document or obtain written statement. Staff interviews from all staff working assigned hall/area on alleged day/shift. Obtain or document written statements of interviews. Complete resident interviews from residents on the same hall who received care from alleged employee. Also interview residents who may have seen/heard alleged incident. Reported to the IDOH. Social Services note documented in medical record for each resident documenting psychosocial support provided and continued. Review all documentation above and conclude on the investigation findings...." This citation relates to complaint IN00424700. 3.1-28(d)			