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	02/01/2023

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 Complaint IN00399887. Complaint IN00399887 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600. Survey date: February 1, 2023. Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 5 Medicaid: 42 Other: 7 Total: 54 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 3, 2023.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any correction be considered the letter of credible allegation and request a desk review of certification of compliance on or after 2/22/2023.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation 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,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marilyn Alberson	Health Facility Administrator	02/24/2023

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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	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 observation, interview, and record review, the facility failed to prevent physical abuse for 2 of 4 residents reviewed for abuse (Resident E and Resident B). Findings include: On 2/1/23 at 11:05 a.m., Resident D's door to his room was closed. 1. Resident D's clinical record was reviewed on 2/1/23 at 10:25 a.m. Diagnoses included alcohol dependence, uncomplicated, anxiety disorder, delusional disorders, alcohol use, with alcohol-induced persisting dementia, psychotic disorder with hallucinations due to known physiological condition, vascular dementia, moderate, with agitation, other behavioral disturbance, psychotic disturbance, and mood disturbance. An annual MDS (Minimum Data Set), dated 12/16/22, indicated he was severely cognitively impaired. His orders included ziprasidone (treat psychotic disorders) 80 mg (milligrams) twice daily. He had the following current care plans in place: He had exhibited physical and verbal aggression	F 0600	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident E no longer resides at this facility. Resident B no longer resides at this facility. Resident C no longer resides at this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents that reside on Swann have the potential to be affected. Please indicate individualized, behavior-specific interventions in place for Resident D to prevent further aggressive actions towards peers. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Resident D is on 15 minutes checks. When Resident D displays aggressive behaviors the	02/22/2023

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	towards a peer, initiated on 12/6/21. Interventions initiated on 12/30/21 were assess for pain and toileting needs, explain to him that the behavior was inappropriate, talk to him about the feelings and rights of others who are exposed to his negative behavior, he believed another resident was his niece and she would not want him to drive himself and leave the facility. The residents were immediately separated and he was placed on one on ones. His family, medical doctor and psychiatric NP (Nurse Practitioner) were contacted and an order was received to send him to an inpatient psychiatric facility for a psychiatric evaluation and treatment. He exhibited being verbally aggressive towards staff by hitting, spitting on, pushing, cursing, yelling and pulled staff's hair, initiated on 12/12/21. His interventions were to leave him alone, reapproach later and staff would approach in a calm manner, initiated on 12/12/21. Offer fluids and snacks was initiated on 1/7/22. He had potential for psychosocial distress related to an altercation with a peer, initiated on 5/25/22. His interventions were to encourage him to participate in activities of interest such as, music, coffee, talking with his family, and provide one on one as needed, initiated on 5/25/22. He exhibited verbal aggression, exit seeking, yelling at staff, and was non-complaint with the smoke break policy. He paced, made repetitive movements, had increased agitation, refused medication, refused to shower, cursed at staff, made repetitive verbalizations, repetitive questions and slammed doors, initiated on 6/15/22. His intervention was to attempt to remind him the behavior was not appropriate, initiated on 6/15/22.		individualized interventions include: · Assess for pain and toileting needs · Explain to resident that behavior is not appropriate · 15 minute checks · Discourage other residents from entering his room · Talk to him about the feelings and rights of others who are exposed to negative behavior · Offer an Activity · Attempt to redirect the conversation · Encourage verbalization and expression of feelings · Talk with resident about his past interests · Explain all care prior to and during care · Explain the importance of care · Offer him to call his daughters · Call his daughters to come in and be with him · Snacks as wanted · Coffee as wanted · Provided non-alcoholic wine Please indicate staff education implemented regarding aggressive resident behaviors and individualized interventions. Please see attachments 1 and 2.Staff in-serviced on February 22, 2023 How the corrective action(s) will be	

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	His nurses notes indicated the following: On 10/30/22 at 1:13 p.m., he and another resident were in the hall near the nurses station. The other resident was moaning and making noises. Resident D told him to shut up and raised his hand as if to slap the other resident. The CNA was able to catch his hand before he struck the other resident. Both residents were separated and sent to their individual rooms. On 11/22/22 at 4:10 p.m., Resident D and Resident E were involved in a physical altercation. Resident E approached Resident D and called Resident D a name. Resident D swung at Resident E and made contact to his left cheek/ear area. Resident E swung back and made contact to Resident D's right upper chest. Resident E started to swing back at Resident D, then Resident D swung back at Resident E and made contact to Resident E's left cheek and arm and he fell to the floor to his buttocks. Resident E had an abrasion to his left ear with scant amount of blood, slight bruising to his left cheek, and redness to his knuckles on his left hand. On 11/25/22 at 7:15 p.m., Resident D was sent to the emergency room for aggressive behaviors. On 11/26/22 at 4:00 a.m., Resident D returned to the facility with a new order for lactulose (to decrease ammonia levels). On 12/6/22 at 5:30 p.m. Resident D became verbally and physically aggressive with Resident B. The SSD (Social Service Director) attempted to maintain a safe distance between residents but due to the resident's height, he was able to make contact with Resident B, who was facing the		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The QAA committee will monitor the effectiveness of the interventions weekly for 4 months and then monthly for 2 months. This monitoring will continue until 100% compliance is achieved for 2 consecutive months.	

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	facility exit door. An attempt was made to redirect Resident D but he continued to be verbally aggressive. Resident B was removed from the area. A new order was obtained to send the resident out for evaluation. On 12/7/22 at 6:31 a.m., he returned to the facility with no new orders. On 1/15/23 at 4:37 p.m., he became agitated when Resident B started to walk into his room. Resident D started cursing at Resident B and punched Resident B in the left side of his back/shoulder area. Review of a facility reported incident for Resident D and Resident E, dated 11/22/22 at 4:01 p.m., indicated the resident had approached the other resident and called him names then punched him. The other resident had defended himself. 2. Resident E's clinical record was reviewed on 1/31/23 at 10:45 a.m. Diagnoses included other drug induced movement disorders, major depressive disorder, recurrent severe without psychotic features, dysphagia, post-traumatic stress disorder, chronic, personal history of traumatic brain injury, unspecified dementia, severe, with agitation, anxiety, psychotic disturbance and mood disturbance. An admission MDS, dated 10/13/22, indicated he was moderately cognitively impaired. His nurses notes indicated the following: On 11/22/22 at 4:35 p.m. Resident E exhibited verbal and physical aggression towards a peer. There had been a physical altercation between Resident E and Resident D.			

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	On 11/22/22 at 4:40 p.m., a referral packet was sent to a psychiatric inpatient facility. On 11/22/22 at 5:48 p.m., the nurse was called to the unit by the QMA, as Resident E had called Resident D a derogatory name. Resident D had swung at Resident E and made contact on Resident E's left cheek/left ear area. Resident E swung back at Resident D and made contact to Resident E's right upper chest. Resident E started to swing back at Resident D and Resident D swung back at Resident E and made contact to Resident E's left cheek and and left arm. Resident E sat down on his buttocks. Resident E had a small abrasion to his left ear with a scant amount of blood and slight bruising to his left cheek. On 11/22/22 at 7:06 p.m., Resident E was yelling at Resident D again. He was approached by the SSD (Social Service Director) and he became agitated and started yelling at her regarding use of the telephone. The SSD attempted to assist him in using the telephone to speak with his family member and attempted to hand the resident the phone. He wrapped his hand around both her hand and the telephone and yelled this is why I don't like to do this kind of thing. The SSD asked the resident to let go of her hand, which he did, and then took the phone from her. On 11/23/22 at 7:41 a.m., the residents were separated. On 11/23/22 at 1:02 p.m., Resident E was sent to a psychiatric inpatient facility. 3. Review of a facility reported incident, dated 1/15/23 at 3:30 p.m., indicated Resident B was walking down the hallway when Resident D hit			

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	him in the back. Resident B's clinical record was reviewed on 2/1/23 at 9:29 a.m. Diagnoses included dementia in other diseases classified elsewhere, severe, with other behavioral disturbance, alcohol dependence, uncomplicated, depression, Wernicke's encephalopathy, hallucinations, delusional disorders, generalized anxiety disorder, and violent behavior. His current orders included the following: buspirone (anti-anxiety) 5 mg three times daily, haloperidol (treat psychotic disorder) 5 mg three times daily, sertraline (depression) 50 mg daily, and trazodone (sleep) 50 mg daily. An admission MDS, dated 11/9/22, indicated he was moderately cognitively impaired. His care plans included: He wandered aimlessly without regards to needs or safety on his assigned hall, initiated on 11/3/22. The interventions were involve him in a diversional activities as possible and redirect him away from doors, initiated on 11/3/22. He was involved in a peer to peer altercation, initiated on 1/21/23. His interventions that were initiated on 12/6/22 were approach him in a calm manner and call him by his name. A nurses note, dated 1/15/23 at 4:32 p.m., indicated Resident B was walking towards Resident D when Resident D started cursing at Resident B and doubled up his fist and hit Resident B on his back/shoulder area. 3. A facility reported incident, dated 1/21/23 at			

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	10:01 p.m., indicated Resident C had struck Resident B on his left hand with his cane. Resident C's clinical record was reviewed on 2/1/23 at 10:07 a.m. Diagnoses included cognitive communication deficit, major depressive disorder, recurrent, dementia in other diseases classified elsewhere, unspecified severity with other behavioral disturbance, and anxiety disorder. An admission MDS assessment, dated 12/31/22, indicated he was cognitively intact. He had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) one to three days of the assessment period. He had a current care plan, initiated on 12/28/22, for verbal aggression and yelling at staff. His interventions were to assess for pain and toileting needs and offer a snack or drink, initiated on 12/28/22. A nurses note, dated 1/21/23 at 10:00 p.m., indicated the QMA reported a resident to resident altercation. No injuries were noted to this resident. New orders were to send to him to the emergency room for evaluation and treatment. A nurses note, dated 1/22/23 at 7:02 a.m., indicated he returned to the facility with no new orders. He had a care plan problem of a skin tear/potential			

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	for skin tear to his left hand related to a resident to resident altercation, initiated on 1/22/23. He had a care plan problem of risk for acute pain related to a fracture of the fifth digit of his left hand, with bruising noted, initiated on 1/22/23. A nurses note, dated 1/21/23 at 10:00 p.m., indicated the QMA reported there had been a resident to resident altercation. Resident B received injuries to his left hand, a 2 cm x 2 cm skin tear, and his pinky finger had started to bruise. A new order was received to send him to the emergency room for evaluation and treatment. On 1/22/23 at 2:29 a.m., he returned from the hospital with his left pinky and ring finger in a splint. He was to follow up with orthopedics in five to seven days. He was placed on 15 minute checks. An impression of the x-ray of his left hand, dated 1/21/23 at 11:50 p.m., indicated a comminuted, angulated fracture to the left fifth proximal phalanx. During an interview with LPN 33, on 2/1/23 at 10:58 a.m., she indicated she had worked at the facility for about three weeks. Resident B typically wandered and would wander into other resident's rooms, like Resident D's room. No one was to go into Resident D's room unless it was staff. Resident B had been going into Resident D's room and Resident D came out and argued with him. As they were redirecting Resident B, Resident D had swung and hit Resident B in the middle of his back. They separated them, with Resident D in a chair in the hallway and they had Resident B sit in the nurses station.			

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	During an interview with CNA 7, on 2/1/23 at 11:10 a.m., she indicated that Resident B could be aggressive, was irritable, and wandered into other resident's rooms, which caused behaviors. By looking at his face you could tell what type of mood he was in. Resident C was not a people person, as he was grumpy and used foul language, but she had never seen him be aggressive. She was not working the day of the incident with Resident C and B, but she worked the next day and they were both on 15 minute checks. Resident B was sent for a psychiatric inpatient stay and Resident C went to another facility. Resident E was sexually inappropriate and he would cuss you out. Once he was mad, he would be mad the rest of the day. He paced back and forth. They normally did not have problems with Resident D, but he didn't like other residents in his room and he liked to be by himself. During an interview with LPN 12, on 1/1/23 at 11:30 a.m., she indicated Resident E had sexual behaviors. Resident B would get up without assistance and was a fall risk. She had seen Resident D be verbally aggressive with staff. He could get angry when he wanted something or did not get what he wanted right away, and he was a gruffy guy. You could redirect him with coffee or cigarettes. He did yell at other residents to get away from his room. During an interview with the SSD, on 2/1/23 at 2:11 p.m., she indicated that the CNAs charted the resident's behaviors. The IDT (Interdisciplinary Team) reviewed them and she would make a follow up note. Once she put a follow up note in, she updated the care plans. This included resident to resident altercations. Resident B came from an assisted living, and he had wandering behaviors. He had a texture issue and would rub the walls			

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	and the door frames. She had been caught in the middle of the altercation between Resident B and Resident D on 12/6/22. They tried to put a stop sign on Resident D's door. Resident B would go to the end of the hall next to Resident D's room and rub the edge of the exit door frame. Her back was towards the hallway and Resident D had said something and then went around her to hit Resident B in his ribs. Resident D was normally ok with her. He could be verbal and physically aggressive. Interventions for Resident D were he liked to drink coffee, and at times he would drink non-alcoholic wine to relax him and take extra smoke breaks. Resident C's prior facility paperwork indicated he had behaviors but did not have behaviors until 1/21/23. He was upset and wanted to be with his wife and would be tearful at times. He moved to a facility that was closer to his family, as he was originally from a place three hours away and was having behaviors towards wife and staff. Family was not aware that they were 3 hours away. While here was upset he wanted to be with his wife. In his paperwork said that he had behaviors until the time 1/21/23. Resident B was currently at an inpatient psychiatric facility. Resident E went to a sister facility. An undated facility policy, titled "Abuse and Prevention Policy," provided by the Administrator on 2/1/23 at 1:06 p.m., indicated the following: "...Policy: This facility shall observe the resident's right to remain free from verbal...physical abuse...." This Federal tag relates to complaint IN00399887. 3.1-27(a)(1) 3.1-27(b)			