

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

PRINTED: 06/09/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/05/2023	
NAME OF PROVIDER OR SUPPLIER CARDINAL CARE STRATEGIES				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00399887 completed on February 1, 2023. This visit was in conjunction with the PSR to the Investigation of Complaints IN00400820 and IN00400954 completed on February 17, 2023. This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on March 13, 2023. This visit was in conjunction with the PSR to the Investigation of Complaint IN00405975 completed on April 14, 2023, which resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00399887 - Corrected. Complaint IN00400820 - Corrected. Complaint IN00400954 - Corrected. Complaint IN00405975 - Corrected. Survey dates: May 4 and May 5, 2023 Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type:			{F 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

PRINTED: 06/09/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/05/2023
NAME OF PROVIDER OR SUPPLIER CARDINAL CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Continued From page 1 Medicare: 3 Medicaid: 51 Other: 5 Total: 59 Cardinal Care Strategies was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00399887. Quality review completed May 15, 2023.	{F 000}			