STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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 IN00423123 and IN00423238. Complaint IN00423123 - No deficiencies related to the allegations are cited. Complaint IN00423238 - Federal/State deficiencies related to the allegations are cited at F557. Survey dates: December 11, 12, & 13, 2023 Facility number: 000048 Provider number: 155115 AIM number: 100275330 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 1 Medicaid: 50 Other: 14 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 12/18/2023.	F 0000		
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jamie Corpe | Executive Director | 12/28/2023

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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	personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for resident rights and dignity, were treated in a manner that respected the resident's dignity, when the resident was photographed without permission by a facility employee (Resident B). Findings include: On 12/12/23 at 12:30 P.M., Resident B was observed in her room sitting in a wheelchair near the bed. The resident was well groomed and in appropriate casual wear. During an interview at that time, Resident B, stood from the wheelchair and transferred herself to her bed without difficulty. The resident indicated that she and Employee 2 had become close friends and that she felt like a granddaughter to her. She indicated sometime in June or July of 2023; she sent a text to Employee 2 requesting that she bring a bag of popcorn to her room from a facility activity. Resident B indicated she fell asleep in her room before Employee 2 delivered the popcorn and that she later sent her a text that showed Resident B sleeping in her bed wearing a night shirt. The resident indicated she was uncovered in the picture and that her legs and upper thighs were exposed. Resident B indicated she did not like the way she looked in the picture and that she did not think the employee should have taken her picture without permission even though they were friends.Resident B indicated she reported the incident to the local Ombudsman around 11/25/23 and gave the Ombudsman permission to notify the facility on 12/4/23. When asked why she did	F 0557	**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 violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after January 1, 2024.** **F 557 – Dignity/Right to have Personal Property** **The standard was not met; facility failed to ensure residents were treated in a manner that respected the residents dignity, when the resident was photographed without permission by a facility employee.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Staff member is no longer employed at the facility. Psychosocial follow up completed with resident with no additional	01/01/2024

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	not report the incident to the State Agency, facility Administrator, or Ombudsman earlier, she indicated she didn't know, that the picture did not cause distress, but she didn't like the way she looked in the picture and did not feel Employee 2 should have taken her picture. 12/12/23 at 2:25 P.M., during an interview with the Executive Director, she indicated on 12/04/23 at 1:01 P.M., she was notified by the local Ombudsman that Resident B reported that Employee 2 took a photo of her while she was sleeping in her bed in her room, and without her permission. The Executive Director indicated she immediately notified the State Agency, local police department, Medical Director, began an investigation, and suspended Employee 2 pending an investigation. The Executive Director indicated it was against facility policy for employees to photograph residents without the residents' permission. On 12/13/23 at 10:30 A.M., Resident B's clinical record was reviewed. Resident B was admitted to the facility on 7/06/22. The resident's most resent Minimum Data Set (MDS) was a quarterly assessment, dated 9/26/23. The MDS indicated the resident was cognitively intact, with current diagnosis that included diabetes, hypertension, anemia, and depression. Resident B required limited assistance for transfers, dressing, and personal hygiene. On 12/13/23 at 11:00 A.M., the Executive Director provided Incident #1189. The report indicated on 12/4/23 at 1:01 P.M., the Executive Director was, "... made aware that in June 2023, a staff member took a picture of Resident B without her consent...12/4/23 Employee was immediately suspended pending further investigation...12/9/23		concerns noted. **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 have the potential to be affected by this finding. Facility completed interviews with all residents to ensure no unauthorized photographs have been taken of them by facility staff; no concerns were noted during interviews. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The ED or designee will in-service all current staff regarding resident dignity/privacy rights and company cell usage policy, and new staff thereafter. ED or designee will attend Resident Council monthly, with permission, to ensure residents have no concerns regarding unauthorized photographs being taken of them. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement (QAPI). The	

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	Investigation completed...Appropriate disciplinary action rendered to the staff member [Employee 2]...." On 12/12/23 at 2:46 P.M., the Executive Director provided the current facility policy titled, "Resident Rights," dated 7/23. The policy indicated, "...All staff members recognize the rights of residents at all times...to enable personal dignity, well being...." On 12/13/23 at 11:49 A.M., the Executive Director provided an undated document titled,"Policy Reminder: Mandatory In-Service ALL LOCATIONS Resident's Rights, Privacy, Photographs, Cell Phone Usage and Investigation Cooperation...Resident Rights Except for photographs or recordings taken with advance written consent of an alert and oriented resident, and as obtained only by the Executive Director (ED)...photographing residents at anytime is a violation of resident's rights and privacy...Residents have rights designed to ensure dignity and self-respect..." This concern relates to complaint IN00423238. 3.1-3(a)(u)(3)		ED/designee will be responsible for completing the QAPI audit tool “Dignity & Privacy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for 2 quarters. If threshold of 90% is not met, an action plan will be developed. Finds will be submitted to the QAPI committee for review and follow-up. **By what date the systemic changes will be completed:** January 1, 2024	