STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cardinal Care Strategies	4600 E Jackson St Muncie, IN 47303

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40241 Based on observation, interview and record review, the facility failed to ensure residents had privacy while using the facility telephone. (Swan Unit) Findings include: During an interview with Resident E, on 5/17/24 at 12:22 p.m., she indicated she used the phone at the nurses station and everyone could hear what she talked about. During an interview with the Social Service Director, on 5/17/24 at 2:11 p.m., she indicated she didn't know Resident E needed a phone. They didn't have land lines in the residents' rooms. There was an office phone at the nurses station. She knew while being back in the Swan unit, Resident K would squat down in front of the nurses station to talk on the phone. During an interview with QMA 7, on 5/17/24 at 3:01 p.m., she indicated Resident E talked on the phone at the nurses station when no one was around. Resident E could go as far as the cord would allow her to go to talk privately. During an interview with the Administrator, with the DON present, on 5/21/24 at 11:57 a.m., she indicated some of the residents had cell phones. She had spoken to the Social Service Director about the residents getting government cell phones, and they had some on hand, and just needed to know how to activate them. The residents were able to use the phone at the nurses station, but she didn't want Resident K having to sit on the floor to talk on the phone. During an interview with QMA 7, on 5/21/24 at 2:15 p.m., she indicated there were four residents who used the phone at the nurses station on a regular basis. During an interview with CNA 14, on 5/21/24 at 2:20 p.m., she indicated she sat the nurses station phone on the top of the desk for the residents to use. Sometimes the staff would dial the number for them, or some residents would just pick up the phone and use it. Resident L had a cell phone, but still used the nurses station phone. There was not a private place for the residents to talk on the phone, and they had to stand at the nurses station to talk. During an interview with the Administrator on 5/21/24 at 3:14 p.m., she indicated the facility did not have a policy related to resident's privacy while using a phone. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaint IN00434131. 3.1-3(f)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40241 A. Based on observation, interview and record review, the facility failed to ensure to physician's orders were initiated and implemented for blood glucose monitoring for a resident receiving insulin for 1 of 3 residents reviewed for hospitalization s. (Resident H) B. Based on observation, interview, and record review, the facility failed to monitor resident's bowel movements for 4 of 5 resident's reviewed for bowel management. (Resident B, Resident E, Resident F and Resident H) Findings include: A. Resident H's clinical record was reviewed on 5/21/24 at 9:42 a.m. Diagnoses included type 2 diabetes mellitus without complications, unspecified dementia, severe, with agitation, unspecified dementia, severe, with other behavioral disturbance, unspecified dementia, severe, with psychotic disturbance, unspecified dementia, severe, with anxiety, long term (current) use of insulin, unspecified dementia, unspecified severity, with other behavioral disturbance, type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye, fracture of orbit, unspecified, subsequent encounter for fracture with routine healing, repeated falls and myocardial infarction type 2. Physician's orders included insulin glargine (long acting insulin) 35 units daily with a start date of 9/16/23 and discontinued on 4/29/24, check blood sugar three times (daily before meals and at bedtime) with a start date of 9/15/23, may check blood sugar for signs and symptoms of hypoglycemia/hyperglycemia, notify physician if blood sugar was less than 30 or greater than 400 with a start date of 9/15/23, and insulin glargine 5 units with at start date of 4/30/24. She had a current care plan for being at risk for complications of diabetes mellitus (9/16/23). The goal was her diabetes would be managed with her care plan interventions as evidenced by the absence increased thirst, increased appetite, frequent urination, weight loss, fatigue, muscle cramps, fruity smelling breath, deep labored breathing, lightheadedness, increased sweating, and/or dizziness. Her interventions included check my blood sugars as ordered (9/16/23), she would report and staff would observe for changes in my skin and sensation (9/16/23), she would and staff would observe for signs of hypoglycemia, hyperglycemia and medication side effects (increased thirst, increased appetite, frequent urination, weight loss, fatigue, muscle cramps, fruity smelling breath, deep labored breathing, lightheadedness, increased sweating, and/or dizziness) (9/16/23), observe/document/report as needed (PRN) any signs and symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma (9/16/24), and observe/document/report PRN any sign or symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, and staggering gait (9/16/23). Resident H's documented blood sugars were as follows: On 12/5/23 at 9:57 a.m., it was 245 mg/dL. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/23 at 10:43 a.m., it was 261 mg/dL. On 12/9/23 at 4:05 p.m., it was 167 mg/dL. On 12/10/23 at 8:14 a.m., it was 151 mg/dL. On 12/10/23 at 10:37 a.m., it was 250 mg/dL. On 12/10/23 at 3:54 p.m., it was 180 mg/dL. On 12/12/23 at 9:24 a.m., it was 257 mg/dL. On 4/19/24 at 8:32 a.m. was 119 mg/dL. A facility fall investigation for Resident H, on 4/25/24 at 10:50 p.m., indicated Resident H was found on the floor face down. The fall was unwitnessed. She was bleeding from the face and could not recall what happened, as she had a diagnosis of dementia. She had a left inferior orbital blowout fracture from the fall. The follow up indicated, upon review of hospital results and video, the resident appeared to pass out after standing up from laying on the couch. She stood up and then fell forward. The hospital added a diagnosis of type 2 myocardial infarction. The nurse practitioner concluded that she likely had a medical event resulting in loss of consciousness. Orthostatic blood pressures would be completed twice a day for seven days. Hospital discharge paperwork, dated 4/29/24, indicated Resident H was admitted for falls, altered mental status, and orbital fracture noted on a CAT scan. She was given intravenous fluids and an antibiotic for urinary tract infections, as she was being treated prior to admission to the hospital. She had hypoglycemia (low blood sugar) and needed dextrose-containing intravenous fluids. Her insulin was held. She was discharged on [DATE] after her oral intakes improved, her mental status was back to her baseline, and her sugars were stabilized. Her insulin was decreased to 5 units daily on discharge and her blood sugars should be checked at the facility and monitored closely. The resident's clinical record lacked current orders for blood sugar checks/monitoring. During an interview with the DON and with the Administrator present, on 5/21/24 at 11:57 a.m., she indicated the nurse practitioner put the order in for Resident H to have her blood sugars monitored on 9/15/23 and it didn't flow over to the medication/treatment administration records. When they had an admission or readmission, the DON made a copy of the packet, entered the orders and medication into the computer, took a copy to the MDS Coordinator and then went through the packet and double checked it. Then the original packet got scanned into the clinical records. The packet should have been reviewed. The Administrator indicated they must have missed the order for the blood sugars in September. B.1. Resident B's clinical record was reviewed on 5/17/24 at 10:20 a.m. Diagnoses included ventral hernia without obstruction or gangrene and obesity. Resident B's physician's orders included polyethylene glycol powder (treat constipation) give 17 grams as needed for constipation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Minimum Data Set (MDS) assessment, dated 4/17/24, indicated he was cognitively intact. He required limited assistance with toileting. His bowel continence and constipation were not assessed. He had a care plan problem of potential for constipation (5/20/24). His goal was he would have a movement at least every three days. His interventions included administer medications per physician orders (5/20/24), follow facility bowel protocol for bowel management (5/20/24), he would report and staff would observe for any changes in bowel patterns (5/20/24), and observe/document/report PRN sign and symptoms of complications related to constipation: change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, bradycardia (slow, low pulse), Abdominal distension, vomiting, small loose or stools, fecal smearing, bowel sounds, diaphoresis, abdomen tenderness, guarding, rigidity, and fecal compaction (5/20/24). Resident B's clinical record lacked bowel movement monitoring documentation on the following dates in April and May 2024: 4/11/24, 4/12/24, 4/13/24, 4/14/24, 4/15/24, 4/16/24, 4/17/24, 4/18/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/24/24, 4/25/24, 4/26/24, 4/27/24, 4/28/24, 4/29/24, 4/30/24, 5/1/24, 5/2/24, 5/3/24, 5/4/24, 5/5/24, 5/6/24, 5/7/24, 5/8/24, 5/9/24, 5/10/24, 5/11/24, 5/12/24, and 5/13/24. B.2. Resident E's clinical record was reviewed on 5/20/24 at 10:48 a.m. Diagnoses included constipation. Physician's orders included refer to gastrointestinal for irritable bowel syndrome and constipation, sennosides (treat constipation) 8.6 milligram (mg)daily, bisacodyl (treat constipation) 10 mg as needed for constipation twice daily, sodium phosphates (treat constipation) rectal enema one as needed daily, magnesium hydroxide 30 milliliter (ml)every 24 hours as needed, and polyethylene glycol (treat constipation) one scoop mixed with six to eight ounces of water at bedtime. A quarterly MDS assessment, dated 5/2/24, indicated she was cognitively intact and required supervision for toileting. She was always incontinent of bowel. She had a care plan problem of potential for constipation related to medication and required staff assistance to obtain water/fluids of choice (10/7/22). Her goal was she would have a bowel movement at least every three days utilizing care plan interventions. Her interventions included administer medications per physician orders (10/7/22), encourage consumption of fluids (10/7/22), encourage resident to sit on toilet to evacuate bowels if possible (2/19/24), follow facility bowel protocol for bowel management (2/19/24), she would report and staff would observe for any changes in bowel patterns (10/7/22), monitor medications for side effects of constipation and keep physician informed of any problems (2/19/24) and observe/document/report PRN sign and symptoms of complications related to constipation: Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, bradycardia (slow, low pulse), abdominal distension, vomiting, small loose or stools, fecal smearing, bowel sounds, diaphoresis, abdomen tenderness, guarding, rigidity, and fecal compaction (10/7/22). Resident E's bowel movement monitoring documentation for 4/29/24 through 5/20/24 indicated the following: On 4/29/24 and 4/30/24, she did not have a bowel movement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation on 5/1/24. On 5/2/24 indicated she was continent. On 5/10/24 and 5/11/24, she did not have a bowel movement. The clinical record lacked documentation on 5/12/24. On 5/13/24, 5/14/24 and 5/15/24, she did not have a bowel movement. The clinical record lacked documentation on 5/16/24. On 5/17/24, 5/18/24, and 5/19/24, she did not have a bowel movement. The clinical record lacked documentation on 5/20/24. C.3. Resident F's clinical record was reviewed on 5/20/24 at 11:36 a.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and need for assistance with personal care. Physician's orders included docusate sodium (treat constipation) 100 mg twice daily, magnesium hydroxide (treat constipation) 30 ml by mouth at bedtime, sodium phosphates rectal enema 133 ml every 24 hours as needed. A quarterly MDS assessment, dated 3/18/24, indicated she was cognitively intact and required extensive assistance from one staff member for toileting. She was always continent of bowel. She had a current care plan problem of potential for constipation (3/18/22). Her goal was she would have a bowel movement at least every three days utilizing care plan interventions. Her interventions included administer medications per physician orders (3/18/22), encourage consumption of fluids (3/18/22), she would report and staff would observe for any changes in bowel patterns (3/18/22) and observe/document/report PRN signs and symptoms of complications related to constipation: change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, bradycardia (slow, low pulse), abdominal distension, vomiting, small loose or stools, fecal smearing, bowel sounds, diaphoresis, abdomen tenderness, guarding, rigidity, and fecal compaction (3/18/22). Resident F's bowel movement monitoring documentation for 4/17/14 through 5/18/24 indicated the following: On 4/27/24, 4/28/24, and 4/29/24, she did not have a bowel movement. On 5/14/24, 5/15/24, 5/16/24, and 5/17/24, she did not have a bowel movement. On 5/18/24, she was incontinent of bowel. B.4. Resident H's clinical record was reviewed on 5/21/24 at 9:42 a.m. Diagnoses included moderate protein-calorie malnutrition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's orders included sodium phosphates rectal enema 133 ml every 24 hours as needed, loperamide (treat diarrhea) 4 mg every eight hours as needed, glycerin (treat constipation) suppository one rectally as needed every 24 hours if no results after milk of magnesia (treat constipation), and magnesium hydroxide 30 ml every 24 hours as needed. A quarterly MDS assessment, dated 3/18/24, indicated she was severely cognitively impaired and required extensive assistance from one staff member for toileting. She was frequently incontinent of bowel. The resident did not have a care plan for bowel management or constipation. Resident H's bowel movement monitoring documentation indicated the following: On 5/1/24, 5/2/24, and 5/3/24, she did not have a bowel movement. On 5/4/24, she was incontinent of bowel. On 5/17/24, 5/18/24, 5/19/24, and 5/20/24, she did not have a bowel movement. During an interview, on 5/17/24 at 3:01 p.m., QMA 7 indicated Resident E had bowel movements every day and facility staff should document the bowel movements in the clinical record. During an interview, on 5/20/24 at 11:59 a.m., CNA 18 indicated she would document the bowel movements at the end of the day. If the resident was continent, she would ask the resident if they had a bowel movement. During an interview, on 5/21/24 at 1:03 p.m., the ADON indicated she monitored the resident's bowel movements when she pulled the information up on the electronic health record dashboard daily. If a resident did not have a bowel movement, they would follow the facility's bowel protocol. The first day after not having a bowel movement for three days, they would give the resident 30 ml of Milk of Magnesia. If that was not successful, on day 2 or three days without a bowel movement, they would give the resident a rectal suppository. If that didn't work, they would complete a bowel assessment and contact the doctor. Resident E did have bowel movements, and the ADON had spoken to the CNAs who had found evidence that Resident E had a bowel movement. Resident F took Milk of Magnesia every night and had not reported constipation. The facility's bowel movement documentation was not completed as it should have been. During an interview with CNA 14, on 5/21/24 at 2:20 p.m., she indicated she charted the consistency and continence of the resident's bowel movements in the clinical record. She charted the bowel movements right after the resident had a bowel movement. If a resident was able to tell her if they had a bowel movement, she would ask them in private. During an interview with LPN 5, on 5/21/24 at 2:24 p.m., she indicated she normally looked at the bowel movement charting, and then the resident for abdominal discomfort. If the resident had not had a bowel movement for three days, the facility would address it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy titled Bowel Management, provided by the Administrator on 5/21/24 at 3:16 p.m., indicated the following: Policy: To see that residents bowel needs are met. Purpose: To assist with establishing a pattern for bowel for bowel function, and to avoid constipation, skin breakdown, and incontinency. In addition, maintain resident dignity and maintain optimum bowel function. Procedure .2. Record bowel movement where appropriate This citation relates to Complaint IN00434131. 3.1-37(a)