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	03/21/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40339 Based on observation and interview, the facility failed to provide and maintain dated storage bags for oxygen administration equipment to be stored in a clean manner for 3 of 3 residents observed for oxygen administration. (Residents J, K, & L) Findings include: During an initial observation on 3/20/25 at 10:16 a.m., a wheelchair was observed outside of Resident K's room with the nasal cannula attached to a portable oxygen tank. The cannula was observed draped over the back of the wheelchair, with the cannula laying in the seat of the chair. There was no storage bag present on the wheelchair. Another wheelchair outside Resident L's room was observed with a nasal cannula attached to a portable oxygen tank. The cannula was observed tucked into a pocket on the back of the wheelchair that was part of the seat. There was no storage bag present on the wheelchair. During an interview with Resident J on 3/21/25 at 10:29 a.m., an oxygen concentrator was observed in the resident's room with the tubing and nasal cannula rolled up and anchored under the handle of the device. There was no dated storage bag on the machine. Resident J indicated there was no bag provided to store her cannula when she was not using it. During an interview on 3/21/25 at 12:09 p.m., the Assistant Director of Nursing/Infection Preventionist indicated the oxygen concentrators should all have dated storage bags on them for the tubing to be stored when not in use. The portable oxygen tanks should also have dated storage bags. There were a couple of residents who continually took the bags off the wheelchairs or concentrators. A current facility policy, revised 1/2023, titled, Oxygen Administration, provided by the Administrator on 3/21/25 at 4:06 p.m., indicated the following: Procedure .11. Oxygen tubing and bag are to be changed and dated every week. 3.1-47(a)(6)

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.

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40339 Based on observation and interview, the facility failed to maintain a clean, orderly shower room for resident use for 1 of 4 shower rooms observed for cleanliness. (100 East hall) Findings include: During an observation of the 100 East hall shower room on 3/20/25 at 10:16 a.m., the following was observed: the floor was soiled and had standing water from the shower to the sink. There were two open soda cans and a plastic bottle of a hydration drink on a shelf. There were plastic wrappers and a bottle of powder in the dirty sink. The toilet bowl had dark rings around the water line. The trash container was uncovered, and a bag of linens was observed on the floor next to the trash container. A sheet was observed draped over the seat of a shower chair and onto the floor. During an observation of the 100 East hall shower room on 3/21/25 at 1:52 p.m., accompanied by the Housekeeping Manager and the Unit Manager, the following was observed: multiple smears of feces on the floor from the shower to the sink, sink visibly dirty, and the toilet bowl had dark rings around the waterline. There were light colored smears on the toilet seat. During an interview at the time of the observation, the Housekeeping Manager indicated the shower rooms should not be in this condition and was an unacceptable way to leave the shower room. A current facility schedule for 3/2025, provide by the Administrator on 3/21/25 at 4:07 p.m., included: .*make sure you are getting your shower rooms Daily .shower rooms. This Federal tag relates to complaint IN00454626. 3.1-18(a)