

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 05/27/2025
NAME OF PROVIDER OR SUPPLIER Cardinal Care Strategies		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interviews and record review, the facility failed to protect a resident's right to be free from verbal abuse by staff for 1 of 3 residents reviewed for abuse. (QMA 1, Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 5/27/25 at 11:40 a.m. Diagnoses included schizophrenia, convulsions, morbid severe obesity with alveolar hypoventilation, and hypertension.</p> <p>Review of a facility self-reportable incident report, dated 4/9/25, indicated on 4/9/25 at approximately 5:30 a. m., QMA 1 was overheard using inappropriate language in a disrespectful manner to Resident D. The incident was reported to the State on 4/9/25 at 10:39 a.m.</p> <p>Review of a written statement by LPN 2, dated 4/9/25, indicated she heard QMA 1 tell Resident D You need to clean your f - - king room. Resident D said What? and was crying. QMA 1 left the room before LPN 2 got to the resident's room. QMA 1 told LPN 2 I'm done. He is a f - - king d - -k. LPN 1 indicated she spent approximately 20-30 minutes with the resident and tried to calm him down. CNA 3 entered the resident's room and stayed with him to help calm him down.</p> <p>During an interview on 5/27/25 at 10:54 a.m. , LPN 2 indicated on 4/9/25 at approximately 5:30 a.m., she overheard QMA 1 yelling and using inappropriate language at the resident. She entered the resident's room and QMA 1 left. She indicated the resident was upset and crying. The resident told her QMA 1 should not have spoken to him like that. LPN 2 did not report this incident to anyone immediately. She indicated QMA 1 had left the area and she felt the resident was safe. CNA 3 entered the room and stayed with the resident until they calmed down.</p> <p>CNA 3 was not available for interview during the survey.</p> <p>QMA 1's employment was terminated and not available for interview during the survey.</p> <p>During an interview on 5/27/25 at 11:30 a.m., Resident D indicated QMA 1 had yelled and cursed at him because his floor was dirty. The incident made him feel bad.</p> <p>During an interview on 5/27/25 at 11:54 a.m., the SSD indicated after she became aware of the incident, she spoke with the resident. The resident told her QMA 1 had hurt his feelings and made him cry.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/27/25 at 12:34 p.m., the DON indicated she arrived at the facility at around 8:00 a. m. on the day in question and was informed of the incident by Unit Manager 4 on 4/9/25 at approximately 10:00 a.m. She immediately informed the Administrator and initiated an investigation. Unit Manager 4 was no longer employed at the facility and was unable to be reached for interview during the survey.</p> <p>During an interview on 5/27/25 at 2:23 p.m., both the Administrator and DON indicated LPN 2 should have immediately informed the Administrator/DON of the incident and QMA 1 should have been sent home immediately.</p> <p>A current policy, dated 2/1/2023, titled Abuse Prevention and Prohibition Policy was provided by the Administrator on 5/27/25 at 11:40 a.m. The policy indicated the following:</p> <p>Purpose: To ensure the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and exploitation.</p> <p>This citation relates to Complaint IN00458662.</p> <p>3.1-27(b)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on record review and interview, the facility failed to implement their facility abuse prevention program policy when staff members failed to report an incident of staff to resident verbal abuse, which delayed the initiation of the facility investigation and reporting to the appropriate agencies, for 1 of 4 residents reviewed for abuse. (QMA 1, Resident D, and LPN 2)</p> <p>Findings include:</p> <p>Review of a facility self-reportable incident report, dated 4/9/25, indicated on 4/9/25 at approximately 5:30 a. m., QMA 1 was overheard using inappropriate language in a disrespectful manner to Resident D. The incident was reported to the State on 4/9/25 at 10:39 a.m.</p> <p>The clinical record for Resident D was reviewed on 5/27/25 at 11:40 a.m. Diagnoses included schizophrenia, convulsions, morbid severe obesity with alveolar hypoventilation, and hypertension.</p> <p>Review of a facility self-reportable incident report, dated 4/9/25, indicated on 4/9/25 at approximately 5:30 a. m., QMA 1 was overheard using inappropriate language in a disrespectful manner to Resident D. The incident was reported to the State on 4/9/25 at 10:39 a.m.</p> <p>Review of a written statement by LPN 2, dated 4/9/25, indicated she heard QMA 1 tell Resident D You need to clean your f - - king room. Resident D said What? and was crying. QMA 1 left the room before LPN 2 got to the resident's room. QMA 1 told LPN 2 I'm done. He is a f - - king d - -k. LPN 1 indicated she spent approximately 20-30 minutes with the resident and tried to calm him down. CNA 3 entered the resident's room and stayed with him to help calm him down.</p> <p>During an interview on 5/27/25 at 10:54 a.m. , LPN 2 indicated on 4/9/25 at approximately 5:30 a.m., she overheard QMA 1 yelling and using inappropriate language at the resident. She entered the resident's room and QMA 1 left. She indicated the resident was upset and crying. The resident told her QMA 1 should not have spoken to him like that. LPN 2 did not report this incident to anyone immediately. She indicated QMA 1 had left the area and she felt the resident was safe. CNA 3 entered the room and stayed with the resident until they calmed down.</p> <p>CNA 3 was not available for interview during the survey.</p> <p>QMA 1's employment was terminated and not available for interview during the survey.</p> <p>During an interview on 5/27/25 at 11:30 a.m., Resident D indicated QMA 1 had yelled and cursed at him because his floor was dirty. The incident made him feel bad.</p> <p>During an interview on 5/27/25 at 11:54 a.m., the SSD indicated after she became aware of the incident, she spoke with the resident. The resident told her QMA 1 had hurt his feelings and made him cry.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/27/25 at 12:34 p.m., the DON indicated she arrived at the facility at around 8:00 a. m. on the day in question and was informed of the incident by Unit Manager 4 on 4/9/25 at approximately 10:00 a.m. She immediately informed the Administrator and initiated an investigation. Unit Manager 4 was no longer employed at the facility and was unable to be reached for interview during the survey.</p> <p>During an interview on 5/27/25 at 2:23 p.m., both the Administrator and DON indicated LPN 2 should have immediately informed the Administrator/DON of the incident and QMA 1 should have been sent home immediately.</p> <p>A current policy, dated 2/1/2023, titled Abuse Prohibition was provided by the Administrator on 5/27/25 at 11:40 a.m. The policy indicated the following:</p> <p>Procedure: Internal Reporting: a. Employees must always report any abuse or suspicions of abuse immediately to the Administrator. **Note: failure to report can make employee just as responsible for the abuse in accordance with State Law.</p> <p>Cross reference F600.</p> <p>This citation relates to Complaint IN00458662.</p> <p>3.1-28(c)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to implement their policy regarding abuse investigation when they failed to provide assessment for psychosocial harm for vulnerable, cognitively impaired residents following an allegation of staff to resident verbal abuse. This deficient practice had the potential to effect 3 of 17 residents living in on the unit where the abuse was alleged. Residents E, F, and G)</p> <p>Findings include:</p> <p>Review of a facility self-reportable incident report, dated 4/9/25, indicated on 4/9/25 at approximately 5:30 a. m., QMA 1 was overheard using inappropriate language in a disrespectful manner to Resident D. The incident was reported to the State on 4/9/25 at 10:39 a.m.</p> <p>The facility's investigation of a verbal abuse allegation was reviewed on 5/27/25 at 9:57 a.m. The investigation included, staff re-education, staff interviews, interviews of cognitively intact residents, and skin assessments. The investigation lacked psychosocial assessments/evaluations of vulnerable or non-verbal residents.</p> <p>1. The clinical record for Resident E was reviewed on 5/27/25 at 10:07 a.m. Diagnoses included anxiety, depression and dementia. The clinical record lacked assessment of psychosocial status during the time of the facility's abuse investigation beginning on 4/9/25.</p> <p>A current quarterly Minimum Data Set (MDS) assessment, dated 3/25/25, indicated the resident was severely cognitively impaired.</p> <p>The resident was not interviewable during the survey.</p> <p>2. The clinical record for Resident F was reviewed on 5/27/25 at 10:11 a.m. Diagnoses included depression, anxiety and dementia. The clinical record lacked assessment of psychosocial status during the time of the facility's abuse investigation beginning on 4/9/25.</p> <p>A current significant change Minimum Data Set (MDS) assessment, dated 4/9/25, indicated the resident was not interviewable.</p> <p>The resident was not interviewable during the survey.</p> <p>3. The clinical record for Resident G was reviewed on 5/27/25 at 10:17 a.m. Diagnoses included Schizophrenia, respiratory failure, and diabetes type 2. The clinical record lacked assessment of psychosocial status during the time of the facility's abuse investigation beginning on 4/9/25.</p> <p>A current quarterly Minimum Data Set (MDS) assessment, dated 34/3/25, indicated the resident was not interviewable due to delusions.</p> <p>The resident was not interviewable during the survey.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/27/25 at 2:23 p.m., the Administrator and DON indicated the facility should have but failed to provide psychosocial assessments for vulnerable residents as part of the investigation.</p> <p>A current policy, dated 2/1/2023, titled Abuse Prohibition was provided by the Administrator on 5/27/25 at 11:40 a.m. The policy indicated the following:</p> <p>,,, a. Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include:</p> <p>ii. Residents' statements</p> <p>a. For non-verbal residents, cognitively impaired or residents who refuse to be interviewed, attempt to interview residents first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings.</p> <p>Cross reference F600.</p> <p>This citation relates to Complaint IN00458662.</p> <p>3.1-28(d)</p>		