

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  12/12/2025
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 - Immediate jeopardy to resident health or safety</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>(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

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  12/12/2025
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to prevent resident to resident sexual abuse of two cognitively impaired residents (Residents F and B) by Resident C, who was cognitively intact with intellectual disabilities, for 2 of 5 residents reviewed for abuse. Resident F was found sitting on Resident C's bed while Resident C had his pants down while seated on the bed, exposing his erect penis and Resident F was observed with saliva on his face and mouth. Later the same day, Resident B was found in his bed with feces and blood on his shirt and incontinence brief, with his brief disheveled, and Resident C was in the same room performing self-gratification of his rectum, with feces and blood on his hands. Resident B indicated to police that Resident C had manipulated his own penis while doing the same to Resident B's penis. The immediate jeopardy began on December 6, 2025 when the facility failed to prevent resident sexual abuse of two cognitively impaired residents by another resident who was cognitively intact with intellectual disabilities. The Administrator and Director of Nursing (DON) were present when informed of the immediate jeopardy on December 11, 2025. The immediate jeopardy was removed on December 11, 2025, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of a 12/7/25 anonymous complaint intake provided to the Indiana Department of Health indicated, over the previous weekend, a dependent resident on the secured behavioral unit was found with feces and blood on him following an incident involving another resident. The anonymous complainant alleged the facility refused to act to protect the residents from further abuse. A police Case Report Summary, dated 12/9/25, indicated on 12/7/25 at 6:16 p.m., a police officer interviewed Resident B with family present. The officer used techniques to allow Resident B to communicate. Resident B had responded he had been touched in a way that was wrong by his former roommate, Resident C. Resident B indicated Resident C had touched his penis. Resident C had grabbed Resident B's penis. Resident C had moved his hand on Resident B's penis in a manner to simulate sex. Resident B indicated Resident C had touched his own penis while touching Resident B's penis. He believed Resident C had ejaculated as he did so. Resident B had told Resident C to stop. He had tried to yell. He had tried to push Resident C away. A facility self-reported incident, submitted to the Indiana Department of Health on 12/7/25 at 8:09 p.m., indicated an incident had occurred on 12/7/25 at 6:03 p.m. Resident B had been touched by his former roommate, Resident C. There were no injuries. The information provided had no indication there was an allegation of sexual abuse. During an interview on 12/10/25 at 1:51 p.m., Resident B's representative indicated they received an anonymous phone call from someone identifying themselves as a staff member. The representative indicated the facility itself had not been forthcoming with information. Based on the anonymous staff phone call, he believed there was a facility attempt to coverup a sexual assault. During an interview on 12/10/25 at 3:04 p.m., CNA 3 indicated he had been working on Saturday 12/6/25. Early that day, he was walking down the hallway and saw Resident C in his room with his pants down. His penis was exposed and erect. Resident F was in Resident C's room. Resident F was seated on the end of Resident C's bed. Resident F had clear liquid, which may have been saliva, all over his mouth. The CNA believed the two residents may have been involved in a mutual sexual activity. He did not want to embarrass them. He asked why Resident C's pants were down and the resident indicated he was going to the bathroom. He asked why Resident F was in the room. Both residents indicated Resident F had come to the room for soda pop. The CNA thought both Resident C and F were intellectually challenged. He immediately informed QMA 5 of what he had witnessed. He had believed QMA 5 was a nurse because she was passing medications that day. To his knowledge, QMA 5 informed the on-call nurse manager. The CNA believed it had been reported to management because Resident F room was moved to a different hallway later that same day. After lunch the same day, CNA 7 had come to get him. She asked him to come see Resident B and Resident C because she had a concern. When he entered the room, Resident B had handprints of fecal matter on the lower part of his shirt. His incontinence brief was messed up and looked like it had been unfastened and an attempt had been made to refasten it. Resident B was not known to pull at his brief. There was fecal matter on the outside of the brief as well. Resident C was also in the room. Resident B had fecal matter all over his hands. The CNAs separated the residents and ensured they were safe. QMA 5 was informed of what they had observed. CNA 3 thought QMA 5 was a nurse. Later that day, Resident B was moved to a new room. CNA 3 later gave a written statement about Residents B and C. During an interview on 12/10/25 at 3:16 p.m. QMA</p>		

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  12/12/2025
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 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>		

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  12/12/2025
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 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report an allegation of resident-to-resident sexual abuse immediately to the Administrator to facilitate protection from further abuse when a cognitively impaired resident (Resident F) was found on the bed of another resident (Resident C) who was exposing his erect penis and Resident F was observed with saliva over his face and mouth for 2 of 5 residents reviewed for abuse (Residents F and B). The facility failed to report the allegation to the State Agency once the Administrator was made aware of the allegations. The facility also failed to accurately report an additional allegation of resident-to-resident sexual abuse later the same day when Resident B was found with feces and blood on his shirt and brief while Resident C was in the same room performing self-gratification of his rectum. Resident B was found in his bed with feces and blood on his shirt and incontinence brief, with his brief disheveled, and Resident C was in the same room performing self-gratification of his rectum, with feces and blood on his hands. Resident B indicated to police that Resident C had manipulated his own penis while doing the same to Resident B's penis. The immediate jeopardy began on December 6, 2025 when the facility failed to report internally to the Administrator and to the State Agency allegations of resident sexual abuse of two cognitively impaired residents by another resident who was cognitively intact with intellectual disabilities. The Administrator and Director of Nursing (DON) were present when informed of the immediate jeopardy on December 11, 2025. The immediate jeopardy was removed on December 11, 2025, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of a 12/7/25 anonymous complaint intake provided to the Indiana Department of Health indicated, over the previous weekend, a dependent resident on the secured behavioral unit was found with feces and blood on him following an incident involving another resident. The anonymous complainant alleged the facility refused to act to protect the residents from further abuse. A police Case Report Summary, dated 12/9/25, indicated on 12/7/25 at 6:16 p.m., a police officer interviewed Resident B with family present. The officer used techniques to allow Resident B to communicate. Resident B had responded he had been touched in a way that was wrong by his former roommate, Resident C. Resident B indicated Resident C had touched his penis. Resident C had grabbed Resident B's penis. Resident C had moved his hand on Resident B's penis in a manner to simulate sex. Resident B indicated Resident C had touched his own penis while touching Resident B's penis. He believed Resident C had ejaculated as he did so. Resident B had told Resident C to stop. He had tried to yell. He had tried to push Resident C away. A facility self-reported incident, submitted to the Indiana Department of Health on 12/7/25 at 8:09 p.m., indicated an incident had occurred on 12/7/25 at 6:03 p.m. Resident B had been touched by his former roommate, Resident C. There were no injuries. The information provided had no indication there was an allegation of sexual abuse. During an interview on 12/10/25 at 1:51 p.m., Resident B's representative indicated they received an anonymous phone call from someone identifying themselves as a staff member. The representative indicated the facility itself had not been forthcoming with information. Based on the anonymous staff phone call, he believed there was a facility attempt to coverup a sexual assault. During an interview on 12/10/25 at 3:04 p.m., CNA 3 indicated he had been working on Saturday 12/6/25. Early that day, he was walking down the hallway and saw Resident C in his room with his pants down. His penis was exposed and erect. Resident F was in Resident C's room. Resident F was seated on the end of Resident C's bed. Resident F had clear liquid, which may have been saliva, all over his mouth. The CNA believed the two residents may have been involved in a mutual sexual activity. He did not want to embarrass them. He asked why Resident C's pants were down and the resident indicated he was going to the bathroom. He asked why Resident F was in the room. Both residents indicated Resident F had come to the room for soda pop. The CNA thought both Resident C and F were intellectually challenged. He immediately informed QMA 5 of what he had witnessed. He had believed QMA 5 was a nurse because she was passing medications that day. To his knowledge, QMA 5 informed the on-call nurse manager. The CNA believed it had been reported to management because Resident F room was moved to a different hallway later that same day. After lunch the same day, CNA 7 had come to get him. She asked him to come see Resident B and Resident C because she had a concern. When he entered the room, Resident B had handprints of fecal matter on the lower part of his shirt. His incontinence brief was messed up and looked like it had been unfastened and an attempt had been made to refasten it. Resident B was not known to pull at his brief. There was fecal matter on the</p>		

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  12/12/2025
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>		

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  12/12/2025
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to initiate investigative protocols and protective interventions for allegations of resident-to-resident sexual abuse for 2 of 5 residents reviewed for abuse (Residents F and B) by Resident C when Resident F was found on the bed of Resident C, who was exposing his erect penis while Resident F was observed with saliva over his face and mouth and when Resident B was found with feces and blood on his shirt and brief while Resident C was in the same room performing self-gratification of his rectum later the same day. Resident B indicated to police that Resident C had manipulated his own penis while doing the same to Resident B's penis. The immediate jeopardy began on December 6, 2025 when the facility failed to immediately implement facility policy and protocols to investigate allegations of sexual abuse of two cognitively impaired residents by another resident who was cognitively intact with intellectual disabilities. The Administrator and Director of Nursing (DON) were present when informed of the immediate jeopardy on December 11, 2025. The immediate jeopardy was removed on December 11, 2025, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of a 12/7/25 anonymous complaint intake provided to the Indiana Department of Health indicated, over the previous weekend, a dependent resident on the secured behavioral unit was found with feces and blood on him following an incident involving another resident. The anonymous complainant alleged the facility refused to act to protect the residents from further abuse. A police Case Report Summary, dated 12/9/25, indicated on 12/7/25 at 6:16 p.m., a police officer interviewed Resident B with family present. The officer used techniques to allow Resident B to communicate. Resident B had responded he had been touched in a way that was wrong by his former roommate, Resident C. Resident B indicated Resident C had touched his penis. Resident C had grabbed Resident B's penis. Resident C had moved his hand on Resident B's penis in a manner to simulate sex. Resident B indicated Resident C had touched his own penis while touching Resident B's penis. He believed Resident C had ejaculated as he did so. Resident B had told Resident C to stop. He had tried to yell. He had tried to push Resident C away. A facility self-reported incident, submitted to the Indiana Department of Health on 12/7/25 at 8:09 p.m., indicated an incident had occurred on 12/7/25 at 6:03 p.m. Resident B had been touched by his former roommate, Resident C. There were no injuries. The information provided had no indication there was an allegation of sexual abuse. During an interview on 12/10/25 at 1:51 p.m., Resident B's representative indicated they received an anonymous phone call from someone identifying themselves as a staff member. The representative indicated the facility itself had not been forthcoming with information. Based on the anonymous staff phone call, he believed there was a facility attempt to coverup a sexual assault. During an interview on 12/10/25 at 3:04 p.m., CNA 3 indicated he had been working on Saturday 12/6/25. Early that day, he was walking down the hallway and saw Resident C in his room with his pants down. His penis was exposed and erect. Resident F was in Resident C's room. Resident F was seated on the end of Resident C's bed. Resident F had clear liquid, which may have been saliva, all over his mouth. The CNA believed the two residents may have been involved in a mutual sexual activity. He did not want to embarrass them. He asked why Resident C's pants were down and the resident indicated he was going to the bathroom. He asked why Resident F was in the room. Both residents indicated Resident F had come to the room for soda pop. The CNA thought both Resident C and F were intellectually challenged. He immediately informed QMA 5 of what he had witnessed. He had believed QMA 5 was a nurse because she was passing medications that day. To his knowledge, QMA 5 informed the on-call nurse manager. The CNA believed it had been reported to management because Resident F room was moved to a different hallway later that same day. After lunch the same day, CNA 7 had come to get him. She asked him to come see Resident B and Resident C because she had a concern. When he entered the room, Resident B had handprints of fecal matter on the lower part of his shirt. His incontinence brief was messed up and looked like it had been unfastened and an attempt had been made to refasten it. Resident B was not known to pull at his brief. There was fecal matter on the outside of the brief as well. Resident C was also in the room. Resident B had fecal matter all over his hands. The CNAs separated the residents and ensured they were safe. QMA 5 was informed of what they had observed. Later that day, Resident B was moved to a new room. CNA 3 later gave a written statement about Residents B and C. During an interview on 12/10/25 at 3:16 p.m., QMA 5 indicated CNA 3 came to get her on Saturday 12/6/25 around 3:15 p.m. to look at Resident B. The QMA</p>		