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	05/13/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure actions were taken to prevent further abuse, when a staff member left a resident with the alleged perpetrator after witnessing an alleged act of resident to resident abuse (Residents B and C) and failed to complete a thorough investigation according to the facility's policy following an allegation of resident to resident sexual abuse for 1 of 2 incidents reviewed for abuse. (Residents B and C)Findings include:On 5/12/26 at 11:31 a.m., Resident B sat in her wheelchair in her room with her television on. She indicated, a few days ago, she invited Resident C to her room to talk as friends. He came into her room, shut her door, removed her incontinence brief, and put his finger in her vagina. She was not comfortable with his actions. She yelled out for him to stop and one of the staff members came into her room. She did not want him to do that to her. She felt safe in the facility.A facility investigation file, observed on the conference room table on 5/12/26 at 11:49 a.m., contained Resident B's face sheet, orders, care plans, a Trauma Informed Care Review dated 5/10/26, a social service progress note dated 5/11/26 at 11:45 a.m., and Resident C's face sheet, care plan, and orders. The folder included two witness statements as follows: An undated written statement, signed by CNA 6, indicating around 7:20 p.m., CNA 6 opened Resident B's door to her room to bring in supplies. The privacy curtain was pulled, and she heard Resident B saying no and stop, which made CNA 6 pause. Then Resident B said it again. CNA 6 looked around the curtain and saw Resident C standing over Resident B with his pants down and forcing his fingers inside her vagina. Resident B's brief was hanging on the side of the bed. CNA 6 ran and got the QMA and the Nurse. As they all approached the room, Resident C was still forcing his finger inside Resident B's vagina and Resident B said no stop once again. QMA 7 removed Resident C from the room. A written statement, dated 5/10/26 and signed by CNA 42, indicating that she did not witness the incident but went later to check on Resident B. Resident B indicated to CNA 42 that she unstrapped one side of her brief and Resident C undid the other side. She also indicated that she told him no three times and he didn't stop when she told him to stop. A social service note, dated 5/11/26 at 11:45 a.m., indicated the social service designee met with Resident B regarding the incident on 5/10/26. Resident B indicated that she asked another resident to come to her room to talk. The resident took her pants and brief off and touched her while she was saying no. A CNA entered her room and he stopped. The police were notified; Resident B was interviewed and provided a statement. Victims' rights were reviewed with Resident B, and she indicated that she understood. Resident B indicated she was fine and did not appear upset. She was calm with no signs of psychosocial distress. Ongoing psychiatric/social observation would continue as needed and trauma screening was completed.The facility investigation lacked interviews of residents and other staff members to determine if there were other witnesses or additional allegations related to the incident.Resident B's clinical record was reviewed on 5/12/26 at 10:02 a.m. Diagnoses included major depressive disorder, recurrent severe without psychotic features, unspecified psychosis not due to a substance or known physiological condition, unspecified disorder of adult personality and behavior, unspecified symptoms and signs involving cognitive functions and awareness, and other sexual disorders.A 2/26/26 admission MDS (Minimum Data Set) assessment indicated she was cognitively intact and no maladaptive behaviors were exhibited. The resident required a mechanical lift for transfers.Resident (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B's clinical record lacked a physical assessment completed following the incident with Resident C.Resident C's clinical record was reviewed on 5/12/26 at 10:26 a.m. Diagnoses included unspecified dementia, moderate, with other behavioral disturbance, generalized anxiety disorder, and mood disorder due to known physiological condition with manic features.A 2/11/26 admission MDS assessment indicated he was cognitively intact and no maladaptive behaviors were exhibited. A 4/15/26 revised care plan indicated that he exhibited sexually inappropriate behaviors as example by making sexually inappropriate remarks to staff, attempting to kiss staff, attempting to touch staff, etc. Interventions included encouraging him to express why he made statements/comments/remarks (2/4/26), explain/educate that the behavior was not appropriate (2/4/26), let him know what kind of behavior was expected and what would be tolerated (2/4/26), talk to him about feelings and the rights of others who were exposed to acting out (2/4/26), and try to find a cause of the behavior (2/4/26).A 5/11/26 discharge assessment indicated Resident C requested to move to a sister facility.During an interview, on 5/12/26 at 12:33 p.m., with the DON, ADON and the Administrator, the DON indicated no other residents were assessed after the incident regarding Resident B and Resident C. During an interview, on 5/12/26 at 12:48 p.m., the Administrator indicated they had not interviewed other residents related to the incident regarding Resident B and Resident C. During an interview, on 5/13/26 at 11:07 a.m. CNA 39 indicated if she witnessed suspected resident to resident abuse, she would immediately separate the residents and report what she observed to the Administrator or the DON. During an interview, on 5/13/26 at 11:34 a.m., CNA 33 indicated if she witnessed alleged abuse she would scream for the nurse, make sure the residents were safe, and would not leave the residents.During an interview, on 5/13/26 at 1:56 p.m., QMA 7 indicated that she and RN 13 were walking in the hall near the dining room, CNA 6 ran from around the corner of Resident B's hall towards them at the Freedom Hall nurse's station and asking them to come with her quickly. The door to Resident B's room was open, QMA 7 entered Resident B's room, the privacy curtain was pulled, and she heard Resident B saying no and stop. QMA 7 pulled the curtain back, Resident B was lying in bed with her brief open and under her. Resident C was standing beside Resident B's bed with his pants down and his fingers in Resident B's vagina. QMA 7 asked Resident C what he was doing, to stop, and get out of the room. QMA 7 called the Administrator to report what she observed.During an interview, on 5/13/26 at 3:41 p.m., with the Administrator and DON, the DON indicated the nurse on duty was responsible for completing, as soon as possible, an incident report and a progress note including a skin assessment. The nurse would also immediately call the Administrator, notify the nurse practitioner, and obtain witness statements from the staff. Either the Administrator, DON, or Social Services designee would interview other staff members and residents. The Administrator indicated when staff observed abuse, they should immediately separate the residents and make sure they were safe, then notify the Administrator right away. There were no facility policies available related to abuse and immediately separating the residents.A current facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, provided by the DON on 5/13/26 at 3:55 p.m. indicated the following: .Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations.7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident.e. interviews any witnesses to the incident; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors.k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly.This citation relates to Intake 3009932.410 IAC (Indiana Administrative Code) 16.2-3.1-28(d)

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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. Based on observation, interview, and record review, the facility failed to ensure a physical assessment was completed for a resident following an allegation of resident to resident sexual abuse for 1 of 4 residents reviewed for abuse. (Resident B)Findings include:On 5/12/26 at 10:44 a.m., Resident B was observed participating in an activity in the activity room.On 5/12/26 at 11:31 a.m., Resident B sat in her wheelchair in her room with her television on. She indicated, a few days ago, she invited Resident C to her room to talk as friends. He came into her room, shut her door, removed her incontinence brief, and put his finger in her vagina. She was not comfortable with his actions. She yelled out for him to stop and one of the staff members came into her room. She did not want him to do that to her. She felt safe in the facility.A facility investigation file, observed on the conference room table on 5/12/26 at 11:49 a.m., included Resident B's face sheet, orders, care plans, a social service progress note dated 5/11/26 at 11:45 a.m., and Resident C's face sheet, care plan, and orders. The folder included two witness statements as follows: An undated written statement, signed by CNA 6, indicating around 7:20 p.m., CNA 6 opened Resident B's door to her room to bring in supplies. The privacy curtain was pulled, and she heard Resident B saying no and stop, which made CNA 6 pause. Then Resident B said it again. CNA 6 looked around the curtain and saw Resident C standing over Resident B with his pants down and forcing his fingers inside her vagina. Resident B's brief was hanging on the side of the bed. CNA 6 ran and got the QMA and the Nurse. A social service note, dated 5/11/26 at 11:45 a.m., indicated the social service designee met with Resident B regarding the incident on 5/10/26. Resident B indicated that she asked another resident to come to her room to talk. The resident took her pants and brief off and touched her while she was saying no. A CNA entered her room and he stopped. Resident B indicated she was fine and did not appear upset. She was calm with no signs of psychosocial distress. Resident B's clinical record was reviewed on 5/12/26 at 10:02 a.m. Diagnoses included major depressive disorder, recurrent severe without psychotic features, unspecified psychosis not due to a substance or known physiological condition, unspecified disorder of adult personality and behavior, unspecified symptoms and signs involving cognitive functions and awareness, and other sexual disorders.A 2/26/26 admission MDS (Minimum Data Set) assessment indicated she was cognitively intact and no maladaptive behaviors were exhibited. The resident required a mechanical lift for transfers.Resident B's clinical record lacked a physical assessment completed following the incident with Resident C.Resident C's clinical record was reviewed on 5/12/26 at 10:26 a.m. Diagnoses included unspecified dementia, moderate, with other behavioral disturbance, generalized anxiety disorder, and mood disorder due to known physiological condition with manic features.A 2/11/26 admission MDS assessment indicated he was cognitively intact and no maladaptive behaviors were exhibited. During an interview, on 5/12/26 at 12:33 p.m., with the DON, ADON and the Administrator, the DON indicated no other residents were assessed after the incident regarding Resident B and Resident C. During an interview, on 5/13/26 at 1:56 p.m., QMA 7 indicated that she and RN 13 were walking in the hall near the dining room, CNA 6 ran from around the corner of Resident B's hall towards them at the Freedom Hall nurse's station and asking them to come with her quickly. The door to Resident B's room was open, QMA 7 entered Resident B's room, the privacy curtain was pulled, and she heard Resident B saying no and stop. QMA 7 pulled the curtain back, Resident B was lying in bed with her brief open and under her. Resident C was standing beside Resident B's bed with his pants down and his fingers in Resident B's vagina. QMA 7 asked Resident C what he was doing, to stop, and get out of the room. QMA 7 called the Administrator to report what she observed.During an interview, on 5/13/26 at 3:41 p.m., with the Administrator and DON, the DON indicated the nurse on duty was responsible for completing, as soon as possible, an incident report and a progress note including a skin assessment. A current facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, provided by the DON on 5/13/26 at 3:55 p.m. indicated the following: .Investigating Allegations 1. All (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegations are thoroughly investigated. The administrator initiates investigations.7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident.This citation relates to Intake 3009932.410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)