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	01/09/2026

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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, intervew, and record review, the facility failed to ensure menus were followed in order to ensure accurate portion size for entrees served. This deficient practice had the potential to impact 81 of 81 residents, who recieved meals prepared by the facility. Findings include: During a lunch meal service observation on 1/5/26 from 11:25 a.m. to 11:37 a.m., [NAME] 16 was observed scooping a 4-ounce portion of beef and noodles and placing it on nine meal trays. During an interview on 1/05/2026 at11:37 a.m., [NAME] 16 indicated the nine resident meal trays she had served, and the staff had placed on the meal cart, were ready for meal service and no additional items were needed for service. She indicated she had served 4 ounces of beef and noodles on each of the meal trays. During an observation and interview with the Dietary Manager on 1/5/2026 at 11:38 a.m., the Dietary Manager reviewed the menu and portion size guide and indicated all resident should have been served an 8-ounce (1 cup) serving of beef and noodles. She indicated an additional 4 ounces of beef and noodles would need to be added to the nine already prepared resident meal plates before they would be served. During an interview on 1/9/26 at 2:00 p.m., the ADON indicated all 81 residents ate meals prepared by the facility kitchen. A current, 9/19/25, facility menu for the 1/5/26 lunch meal, provided by the Administrator on 1/5/26 at 11:46 a.m., indicated the portion size for beef and noodles was 8 ounces for every diet type served. A current, 6/7/21, policy titled, Dietary, provided by the Administrator on 1/6/26 at 1:02 p.m., indicated Every effort will be made to serve the items on the posted menu . 1.3-20(i)

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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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to provide a surety bond which covered the total amount of resident funds. This deficient practice had the potential to impact 71 of 71 residents who had their funds managed by the facility. Findings include:During a review of resident funds with the Business Office Manager (BOM) on 1/9/26 at 9:27 a.m., she provided a list of residents for whom the facility managed funds, the last months bank statement, and a copy of the surety bond.The 1/8/26, Trial Balance report provided by the BOM on 11/9/26 at 9:27 a.m., indicated the facility managed resident funds for 71 residents.The current, 1/4/22, Surety Bond policy, provided by the BOM on 1/9/26 at 9:27 a.m., indicated the resident funds account was ensured for $80,000.00 (eighty thousand dollars). The Business Checking With Interest Account Statement, for the period of 11/29/25 to 12/31/25, provided by the BOM on 1/9/26 at 9:27 a.m., indicated the ledger balance on three occasions exceeded $80,000.00 dollars as follows:12/3/25 $116,270.81 ($36,270.81 an excess of $80,000)12/4/25 $115,892.81 ($35,892.81 an excess of $80,000)12/5/25 $115,657.81 ($35,657.81 an excess of $80,000) The Business Checking With Interest Account Statement, for the period of 11/01/25 to 11/28/25, provided by the Administrator on 1/9/26 at 2:00 p.m., indicated the ledger balance on two occasions exceeded $80,000.00 dollars as follows:11/3/25 $80,669.58 (an excess of $669.58)11/4/25 $80,327.58 (an excess of $327.58) The Business Checking With Interest Account Statement, for the period of 10/01/25 to 10/31/25, provided by the Administrator on 1/9/26 at 2:00 p.m., indicated the ledger balance on fourteen occasions exceeded $80,000.00 dollars as follows:10/1/25 $158,187.52 (an excess of $78,187.52)10/2/25 $156,009.52 (an excess of $76,009.52)10/3/25 $195,004.68 (an excess of $115,004.68)10/6/25 $155,466.19 (an excess of $75,466.19)10/7/25 $156,048.19 (an excess of $76,048.19)10/8/25 $163,281.37 (an excess of $83,281.37)10/9/25 $156,235.37 (an excess of $76,235.37)10/10/25 $155,432.11 (an excess of $75,432.11)10/14/25 $152,695.14 (an excess of $72,695.14)10/15/25 $152,056.54 (an excess of $72,056.54)10/16/25 $151,873.54 (an excess of $71,873.54)10/17/25 $152,052.54 (an excess of $72,052.54)10/20/25 $151,580.00 (an excess of $71,580.00)10/21/25 $151,474.00 (an excess of $71,474.00) During an interview on 1/9/26 at 2:30 p.m., the Administrator indicated the facility had balances in excess of $80,000.00. The corporation did review balances each business day. The corporation believed since the removal of resident liability took the balance down below $80,000.00, they didn't need to ensure the excess amounts. A policy and procedure was requested on 1/9/26 a 2:30 p.m., but was not provided by the time of exit on 1/9/26.3.1-6(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were stored securely without loose pills for 2 of 4 medication carts reviewed. (100 East and 100 West) Findings include:During an observation of the 100 East medication cart with QMA 10 on 1/7/26 at 8:43 a.m., one yellow ovate pill inscribed with H125 and one white ovate pill inscribed with L612 were found in the 3rd drawer on the right-hand side. A white circle pill with no visible marking was found in the 2nd drawer on the right-hand side. During a concurrent interview QMA 10 indicated no loose pills should have been found in the medication cart. During an observation of the 100 [NAME] medication cart with LPN 9 on 1/8/26 at 8:23 a.m., one white circular pill inscribed with RE22 was found in the 2nd drawer on the right-hand side. Two yellow circular pills inscribed with L20 were found in the 3rd drawer on the right-hand side. During an interview at the time of the observation, LPN 9 indicated no loose pills should have been found in the medication cart. Any loose pills found should have been discarded appropriately. During an interview on 1/9/26 at 10:33 a.m., the ADON indicated no loose pills should have been found in the medication carts. Unit managers performed weekly storage audits on the medication carts. The pharmacy also came to the facility monthly and performed medication cart audits. During an interview on 1/9/26 at 4:27 p.m., the ADON indicated no medication cart audits had been performed since 12/18/25. A current facility policy revised October 2024, titled Medication Labeling and Storage, provided by the ADON on 1/9/26 at 11:27 a.m. indicated the following: .1. Medication and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. W. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 3.1-25(m)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interview and record review, the facility failed to provide notice of a roommate change to the resident prior to receiving a new roommate for 1 of 3 residents reviewed for resident rights. (Resident B) Finding includes:Resident B's clinical record was reviewed on 1/7/26 at 2:51 p.m. Diagnoses included opioid abuse, alcohol use, chronic pain, major depressive disorder, and anxiety disorder. A 10/9/25, significant change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident required set-up assistance for all activities of daily living. During an interview on 1/7/26 at 3:18 p.m., Resident B indicated he did not currently have a roommate. In December, approximately 3 weeks ago, the facility brought a new roommate into his room. Resident B had been out of his room and did not know he had a roommate until he returned to his room, and the new roommate was already there. The clinical record lacked a notification to Resident B prior to receiving a roommate (on 12/17/25). During an interview, on 1/8/26 at 3:42 p.m., the ADON indicated the Social Service Director (SSD) was the staff member who gave notices to the residents when they were going to receive a roommate. On 1/8/26 at 3:46 p.m., the SSD indicated Resident B received a new roommate on 12/17/25 due to a previous roommate incompatibility. This corporation did not have a room transfer notification form. She notified residents verbally when they were going to get a roommate and typically made a progress note indicating when she notified them. The SSD indicated she was unable to provide evidence to indicate Resident B was notified prior to receiving a roommate on 12/17/25. Resident B would be able to accurately indicate whether he had been notified or not. On 1/9/26 at 2:06 p.m., the Corporate Nurse Consultant indicated residents had the right to be notified prior to receiving a new roommate. A current document, undated, titled Your Rights and Protections as a Nursing Home Resident, provided by the ADON on 1/9/26 at 9:04 a.m., indicated the following: .As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need. You have the right to be informed. At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right too: . Get Proper Privacy, Property, and Living Arrangements: . The nursing home has to notify you before your room or your roommate is changed and should take your preferences into account. This citation relates to Intake 2697288. 3.1-3(v)(2)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to provide the appropriate Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) for residents discharged from Medicare A skilled services for 2 of 2 residents reviewed for Beneficiary Notifications. (Residents 3 and 43) Findings include:On 1/8/26 at 1:31 p.m., the facility's Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review Forms were reviewed, and indicated the following:1.Resident 3 was admitted to Medicare A Skilled Services on 12/3/25. The last covered day was 12/17/25. The SNF Notice of Medicare Non-Coverage (NONMC) was reviewed with the resident and/or resident representative and signed on 12/15/25. The SNF NONMC indicated the resident was discharged from therapy. The clinical record lacked a SNF ABN. 2. Resident 43 was admitted to Medicare A Skilled Services on 11/27/25. The last covered day was 12/5/25. The SNF NONMC was reviewed with the resident and/or resident representatives and signed on 12/3/25. The SNF NONMC indicated the resident discharged from therapy. The clinical record lacked a SNF ABN. During an interview, on 1/8/26 at 1:45 p.m., the BOM and Therapy Director indicated they completed the SNF NONMC paperwork together after a resident was discharged from Medicare A services. They thought the SNF NONMC and the SNF ABN form was the same form. Residents 3 and 43 only received the SNF NONMC form. They indicated they had not received training on the proper use of the SNF ABN form. During an interview, on 1/8/25 at 4:25 p.m., the Corporate Nurse Consultant indicated the facility did not have a policy related to Beneficiary Notifications. According to the Centers for Medicare and Medicaid Services (CMS) website page Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN), located at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/snfabn-instructionsv508_clean-11 retrieved on 1/12/25 at 12:47 p.m., indicated .These abbreviated instructions explain when and how the SNF ABN must be delivered .Medicare requires Skilled Nursing Facilities (SNFs) to issue the SNF ABN to Original Medicare . patients prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial. The SNF ABN provides information to the patient so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility . 3.1-4(f)(3)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to prevent resident-to-resident abuse from a resident known to have a history of a resident-to-resident altercation and anger outbursts (Resident B) to a cognitively dependent resident for 1 of 3 residents reviewed for abuse. (Resident 76) Findings include:Resident B's clinical record was reviewed on 1/7/26 at 2:51 p.m. Diagnoses included opioid abuse, alcohol use with intoxication, chronic pain, major depressive disorder, and anxiety disorder. A 10/9/25, significant change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident required set-up assistance for all activities of daily living. He used a motorized wheelchair for mobility. The resident's preferences indicated it was very important to take care of his personal belongings and somewhat important to have a place to keep his personal belongings safe. Resident B's current care plans indicated the following: An 8/7/25, care plan for risk of psychosocial distress related to anxiety disorder and major depressive disorder. The resident had the potential to exhibit the following behaviors: increased agitation, verbal outbursts, cursing/profane language, self-isolation, and negative statements. Interventions included: request assistance from administration, DON, or Social Services in answering questions or concerns the resident might have that cannot be easily addressed by nursing staff (8/7/25). A 9/11/25, care plan related to mental illness related to generalized anxiety disorder, major depressive disorder, alcohol use, alcohol withdrawal, and opioid abuse without specialized services was in place. Interventions included supportive counseling from nursing facility staff (9/11/25) and a behaviorally based treatment plan (9/11/25). A 12/19/25, care plan for the potential to be physically aggressive related to anger. Resident B was physically aggressive toward another resident by pushing. Interventions included administer medications as ordered (12/19/25), psychiatric consultation as indicated (12/19/25), intervene before agitation escalates when the resident becomes agitated, guide away from the source of distress, and engage calmy in conversation (12/19/25). The care plan lacked a care plan related to a previous resident-to-resident physical altercation with resident specific interventions to prevent further altercations. Progress notes indicated the following: On 8/26/25, Resident B had a behavior during smoking break. The resident indicated he let his anger get the best of him. On 10/21/25, Resident B was in a resident-to-resident physical altercation and hit another resident. On 12/18/25 at 9:03 p.m., the progress note indicated Resident B was in an incident involving a male roommate. Resident B stated his roommate was going through his closet. Resident B was observed by staff holding his roommate pushed up against the closet door. The roommate did not deny being held against the door. Resident B was visibly upset and demanded to have his roommate removed. Resident B did not deny he pushed his roommate against the closet door. Resident B indicated neither of the residents used their hands to hit each other. The DON and Administration were notified of the incident. On 12/18/25 at 9:37 p.m., no new skin issues were identified for Resident B. During an interview on 1/7/26 at 3:18 p.m., Resident B indicated he did not currently have a roommate. In December, approximately 3 weeks ago, the facility brought a new roommate, Resident 76, into his room without prior notification. Within the first 24 hours of getting his new roommate, he returned to his room when he went to smoke break and found Resident 76 going through his closet. He yelled at Resident 76 and told him to get out of his closet and Resident 76 came at Resident B swinging, so Resident B pushed Resident 76's hands away. Resident B then went out to the hallway and yelled for someone to get Resident 76 out of Resident B's room. Staff came into the room and the residents were still arguing. Resident B did not see Resident 76 take any items from Resident B's closet. Resident B indicated staff interviewed him about what happened, though he was uncertain which staff it was. Resident 76 was immediately removed from his room by staff and moved to a different room. Resident B wished he was introduced to his roommate and informed what he might expect from his (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new roommate. The clinical record lacked indication of a notification to Resident B prior to receiving a new roommate on 12/17/25. On 1/7/25 at 4:25 p.m., the Corporate Nurse Consultant was requested to provide a copy of the facility's entire investigation of the resident-to-resident altercation between Resident B and Resident 76 that occurred in the evening on 12/18/25. During an interview on 1/7/25 at 4:27 p.m., the DON indicated in the evening on 12/18/25, she was not at the facility, but she was notified by an unknown CNA of an altercation between Resident B and Resident 76. The unidentified CNA told her the nurse was busy and asked the unidentified CNA to contact the DON. The unidentified CNA had gone into the resident's room after an altercation and found Resident 76 near the closet and Resident B had pushed Resident 76 back and was yelling at Resident 76. There were three CNAs of unknown identity that the DON spoke with individually over the phone the night of 12/18/25 and obtained detailed descriptions from each of them. The DON could not remember the names of the staff or the times she spoke with them and she could not find the times in her telephone history. The details were included in the facility investigation provided by the Corporate Nurse Consultant per the DON. The aides had recently bathed Resident 76 prior to Resident B returning to his room, when the incident occurred. Resident 76 had a shirt in his hand and Resident B ripped the shirt out of Resident 76's hand and was yelling at Resident 76. The residents were immediately separated prior to the DON receiving notification. Resident 76 had been known to have some Sundower's Syndrome symptoms (increased confusion) in the evenings. As a result, Resident 76 was excited by what had occurred and had to be convinced to leave the room. He was taken to the common area and then moved to a new room. Resident B was upset and screamed at all the staff. Later, she spoke with LPN 11 and ensured both residents had skin assessments completed on them. The DON reported the information to the interim Administrator, at the time, and the Corporate Nurse Consultant. The interim Administrator reported it to the Indiana Department of Health. She also spoke with the SSD who interviewed both residents on 12/19/25. The DON handled the investigation with the soft file in the absence of the Administrator. A review of the facility investigation, provided on 1/7/26 at 4:31 p.m., contained the following information: A recapitulation of the facility reported incident that occurred on 12/18/25 at 8:20 p.m. with a brief description of the resident-to-resident altercation between Resident B and Resident 76. Resident B accused roommate (Resident 76) of stealing clothing from his closet. Resident B was yelling for Resident 76 to get out of his closet. Type of Injury: None. Immediate Action Taken: The staff immediately separated the residents. The nurse completed skin assessments and neither of the residents had any issues identified. Resident 76 was moved to another room. The Administrator and DON were notified immediately of the incident. The provider and responsible parties were notified. Preventative Measures Taken: An investigation was initiated. The nurse completed skin assessment. Residents were separated. Resident 76 was moved to another room and residents were placed on 15-minute safety checks. Both residents were to be seen by psychiatry on their next visit. Psychosocial monitoring will be provided, and the care plan will be reviewed and updated as needed. Resident interviews from Resident B and Resident 76. Three resident interviews regarding safety on a different unit.Fifteen-minute safety checks for Resident B and Resident 76.An Inservice Attendance dated 12/24/25 regarding Resident-to-Resident Abuse Reporting for 112 staff members.The file lacked any staff interviews or the incident report for the altercation. On 1/8/25 at 10:50 a.m., LPN 11 indicated he was on duty on 12/18/25 in the evening at approximately 8:15 p.m. when there was an altercation between Resident B and Resident 76. Resident 76 recently became a new roommate with Resident B. LPN 11 was uncertain of the reason for Resident 76's room change. That evening CNA 25 reported to LPN 11 that Resident B and Resident 76 were in an altercation. Resident B had shoved Resident 76 into the closet door. At that time, Resident B came down the hallway and told LPN 11 he saw Resident 76 going through Resident B's closet. Resident B told LPN 11 he pushed Resident 76. He asked CNA 25 to make a call for him to the DON while he handled assessments/safety. Fifteen-minute checks were initiated on both involved residents. No injuries were found with assessments. Both residents were kept separated and Resident 76 was moved to a different room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNAs were instructed to complete written statements and put them under the DON's door. He observed the CNAs writing their statements before he left at the end of his shift. LPN 11 indicated he did not see where the CNAs put their written statements. Resident B calmed down prior to the end of LPN 11's shift and Resident 76 was calm and resting in bed in his new room at the end of his shift. During a telephone interview on 1/8/26 at 2:52 p.m., CNA 26 indicated she did not see the altercation between Resident B and Resident 76 on 12/18/25, but she was working on that Unit nearby when it occurred and heard the commotion. The other aides that were present on the Unit were CNA 25 and CNA 27. CNA 26 was a few doors down the hallway when she heard yellowing coming from Resident B and Resident 76's room. When she got to the room, she saw Resident B in his motorized wheelchair yelling at Resident 76 not to get in his things anymore. Resident 76 was sitting on the side of his bed and appeared shocked. Some of Resident B's personal items were on the floor in the room. CNA 26 did not see any physical contact between the two residents. She did not know what happened before she got to the room because a lot of threatening language from Resident B directed towards Resident 76 was heard. Resident B was immediately directed out of the room to separate the residents. It was reported to the Administration staff, but since they have had a lot of Administration change in the last few weeks, she was uncertain which Administration staff she spoke with. During an interview on 1/8/26 at 3:33 p.m., LPN 11 indicated Resident B's yelling and pinning Resident 76 up against the closet door on 12/18/25 was aggressive and abusive. Resident 76's clinical record was reviewed on 1/8/26 at 4:56 p.m. Diagnoses included severe vascular dementia with other behavioral disturbances, depression, and anxiety disorder. The resident census indicated Resident 76 was moved to the 300 Unit on 12/17/25, then moved again on 12/17/25 into Resident B's room. On 12/18/25, Resident 76 was moved back to the 300 Unit. All the rooms were located on the secure behavioral unit. Current physician orders for Resident 76 included the following: donepezil hydrochloride (severe vascular dementia with other behavioral disturbance) 10 mg - give one tablet by mouth at bedtime (11/13/25), and memantine hydrochloride (dementia) 5 mg - give one tablet by mouth two times a day (1/2/26). An 11/20/25, admission Minimum Data Set (MDS) assessment indicated Resident 76 was moderately cognitively impaired. No behaviors were exhibited during the assessment period. The resident did not use any mobility devices. He required supervision for all activities of daily living to include transfers and walking 10 feet. Resident 76's current care plans indicated the following: An 11/15/25, care plan for impaired cognitive function related to vascular dementia, benign intracranial hypertension, cerebrovascular disease and mild neurocognitive disorder. Interventions included: cue, reorient and supervise as needed (11/15/25), Keep the resident's routine consistent in order to decrease confusion (11/15/25). A 12/17/25, psychosocial well-being problem related to the fire alarms alarming, sudden room change related to pipe bursting (12/17/25) Interventions included: When conflict arises, remove the resident to a calm safe environment and allow the resident to vent/share feelings (12/17/25). A 12/18/25, potential to be verbally aggressive (yelling) problem, related to ineffective coping skills (12/18/25). Interventions included: Assess the resident's coping skills and support system (12/18/25), Give the resident as many choices as possible about care and activities (12/18/25), and complete a Psychiatric consultation as indicated (12/18/25). A 12/19/25, psychosocial well-being problem related to resident-to-resident altercation. The resident will be observed for any signs and symptoms of mental anguish. Interventions included: When conflict arises, remove the resident to a calm safe environment and allow to vent/share feelings and refer to psychiatric services as needed/ordered. Resident 76's progress notes indicated the following: On 12/18/25 at 11:46 a.m., indicated Resident 76 was verbally aggressive (yelling). Staff were able to intervene. The facility will proceed with the care plan. On 12/18/25 at 8:58 p.m., Resident 76 was up in his room when his roommate confronted him about going through his closet. Resident 76 denied going through his roommate's closet and stated that his roommate pushed him into the door/wall near the bathroom. Resident 76 denied placing hands on his roommate. Resident 76 denied being hit by his roommate. The DON and Administrator were notified. Instructions were received to maintain (continued on next page)

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	155400	A. Building B. Wing	01/09/2026

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	separation of the residents and move Resident 76 to another room for prevention of further incidents. On 12/18/25 at 9:41 p.m., Resident 76's skin lacked any new impairments. Review of Resident 76's fifteen-minute checks indicated the following:On 12/18/25-15-minute checks started at 2:00 p.m. On 12/18/25- 15-minute checks stopped at 6:15 p.m.On 12/18/25- 15-minute checks started at 8:15 p.m. On 12/22/25- 15-minute checks stopped at 6:15 a.m. Interviews indicated the following: On 1/8/26 at 3:46 p.m., the SSD indicated Resident B received a new roommate on 12/17/25 due to a previous roommate incompatibility for Resident 76 earlier in the day on 12/17/25. During a telephone interview on 1/8/26 at 11:17 p.m., CNA 25 indicated she was at the facility on 12/18/25 around approximately 8:15 p.m. when the resident-to-resident altercation happened between Resident B and Resident 76. She was at the nurses' station when [NAME] returned from smoking and went by the nurse station towards his room. When he got to their room, she heard a commotion. She believed it was the noise of the closet door banging and Resident B yelling at Resident 76. She could not determine what exactly was said, but it was in a yelling tone. CNA 25 was the first one to the room and she observed Resident B had Resident 76 pushed up against the closet door. They were immediately separated, then she accompanied Resident 76 down the hallway to the common area. Resident 76 explained that Resident B did not hit him but pushed him into the closet door. The other two aides CNA 26 and CNA 27 remained with Resident B. On 12/18/25 at approximately 8:30 p.m., CNA 25 called the DON to report the altercation between the residents. The DON gave instructions to keep the residents separated, move Resident 76 to another room, and for CNA 25, CNA 26, and CNA 27 to complete written statements for the DON. During a telephone interview on 1/8/25 at 11:41 p.m., LPN 28 indicated she was the nurse on shift for the 200 Unit following LPN 11 the night of 12/18/25 after the altercation occurred between Resident B and Resident 76. Both residents continued 15-minute checks during her shift with no concerns. Resident 76 had been moved to a new room on the 300 Unit. Resident 76 had been placed on the 300 Unit the night of the flood, but when she returned on her next shift he had been moved to Resident B's room and LPN 28 was uncertain why he was placed in the room with Resident B. She was familiar with both residents. Resident B was known to have a history of resident-to-resident altercations in the past as well as having anger outbursts. LPN 28 felt Resident B was not an appropriate roommate candidate for a resident who was not cognitively intact and had increased confusion in the evenings. On 1/9/25 at 2:06 p.m., the Corporate Nurse Consultant indicated pushing another resident into a door and yelling threating language was abusive during the altercation on 12/18/25. The facility needed to carefully consider their choices on room placement during room changes going forward. On 1/9/25 at 3:17 p.m., the DON was requested to provide Resident B and Resident 76's historical care plans as they were not previously included. Additional information was not provided. A current policy, revised 5/2024, titled Abuse Prevention, Identification, and Reporting Policy, provided by the Corporate Nurse Consultant on 1/7/26 at 4:31 p.m., indicated the following: Policy: To establish guidelines for preventing, identifying, and reporting abuse. All residents have the right to be free from abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of the facility to follow the Indiana Department of Health Policies and Procedures for Long-term Care Abuse and Incident Reporting.These procedures shall include. protection of residents and prevention. 3.1-27(a)(1)3.1-27(b)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to ensure residents were free of chemical restraints related to the use of antipsychotic medications without diagnoses for use, identified targeted behaviors for use, documented displayed targeted behaviors, and/or a care plan to address targeted behaviors for 3 of 5 residents reviewed for unnecessary medications. (Residents 5, 6 and 7) Findings include:1. Resident 5's clinical record was reviewed on [DATE] at 2:47 p.m. Diagnoses included Alzheimer's Disease, generalized anxiety, insomnia, and depression. The resident was admitted to the facility on [DATE]. Current physician orders included Risperdal (an antipsychotic medication) 0.5 mg- take one tablet two (2) times daily for agitation. This order originated [DATE] upon admission. A [DATE], admission, Minimum Data Set (MDS) assessment indicated the resident was rarely able to be understood or understand. The staff were interviewed regarding the resident's cognitive status. The resident was identified as having both long- and short-term memory issues. The resident displayed signs of hallucinations during the assessment period. The resident displayed physical and verbal aggression during care. They received antipsychotic medication during the assessment period. A [DATE], Psychiatry Initial Consult indicated the resident had a history ofAlzheimer's disease, anxiety, depression, cognitive communication deficit, and insomnia. Staff report the patient has been irritable and angry at times. The resident received Risperdal 0.5 MG (Risperidone)- Give 1 tablet by mouth two times a day for agitationThe start date was [DATE]. The patient was NOT currently a danger to self/others and had no delusions. The resident had impaired short- and long-term memory.A [DATE] at10:10 a.m., Late Entry Behavior Note indicated a QMA observed the resident smacking a CNA in the face when she was guiding him to recliner to take a nap. The record indicated the resident did not initiate the interaction, but resisted staff interaction to direct him.The record contained documentation of five maladaptive behaviors during the 3-month period. Three of the five behaviors were caused by staff to resident interaction and the resident resisting care. The record did not indicate the resident was agitated or aggressive prior to the staff-initiated interaction. Two of the five events were resident to resident arguments in which the resident could be and was directed from the event. No events show the resident was too agitated to be redirected or initiated an act of aggression without provocation. There were no documented behaviors which indicated the resident displaying psychotic behaviors.A [DATE] at 12:56 a.m., Behavior Note indicated the CNA on duty reported that this resident and another male resident were loudly arguing with one another in lounge earlier in shift. Both residents stated profanities at one another (shut the F up, B***h) and most of the argument was non-nonsensical and could not be understood; body language however was angry with arms waving and pacing in the room. Staff was able to redirect both residents. A [DATE] at 7:08 a.m., Late Entry Behavior Note indicated the QMA observed the resident hitting the writer on three different occasions this shift. Once when attempting to shave him, another while doing personal care, and the last time was when the resident had a book that was nasty and sticky and staff was trying to take the book to clean it. The clinical record indicated the resident responded to the staff's attempt to initiate care and when they attempted to remove an unclean item he was using. The resident did not initiate the interactions.A [DATE] at 8:04 p.m., Behavior Note indicated the resident was attempting to take a cup from another resident and when another resident tried to stop him, he swatted at her and she swatted back at him. Staff took the resident to his room.A [DATE] pharmacy Psychotropic & Sedative/Hypnotic Utilization By Resident report indicated: Resident 5 received Risperidone (Risperdal) 0.5 md two times daily to treat agitation. A medical diagnosis was not listed. A [DATE] at 5 :07 p.m., Behavior Note indicated as staff attempted to take a yellow floor sign from the resident's hands and redirect him, he became somewhat agitated and swung the sign, almost hitting another staff person who was nearby. (No (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact was made.) Eventually, staff was able to redirect him to the dining room in preparation for evening meal. This behavior occurred when staff approached and interacted with the resident. He resisted the interaction as a refusal of care or redirection. He didn't initiate the interaction.The resident's clinical record lacked an identified targeted behavior for the use of the antipsychotic medication Risperdal. The record lacked a diagnosis for the use of an antipsychotic medication. The clinical record lacked a care plan related to targeted behaviors being treated by the antipsychotic medication Risperdal. During an observation on [DATE] at 11:08 a.m., Resident 5 was walking in the hallway. He had his head down. He was calm.During an observation on [DATE] at 12:05 p.m., Resident 5 was seated calmly at the dining room table awaiting meal service. During an observation on [DATE] at 9: 48 a.m., Resident 5 was ambulating by the nursing station. He walked to the doors, turned around, and walked the other direction. During an interview on [DATE] at 2:42 p.m., C.N.A. 13 indicated Resident 5 did get startled and then want people to stay away from him. He had, at times, resisted care. He never initiated aggression, he just got upset when staff startled him or attempted to provide care he didn't desire. He was usually calm. He walked around without true direction and could go into areas he did not belong in.During an interview on [DATE] at 2:46 p.m., QMA 14 indicated Resident 5 could We be resistant to care and become agitated. He did not approach staff in an agitated state care agitated him. She had never witnessed him display any hallucinations or delusions. During an interview on [DATE] at 2:51 p.m., RN 15 indicated Resident 5 wandered and was at times resistant to care or redirection. He did not display signs of delusions or hallucinations. He did not approach others with aggression or agitation. He became upset with care or redirection. 2. Resident 6's clinical record was reviewed on [DATE] at 10:35 a.m. Current diagnoses included major depressive disorder, bipolar disorder, and anxiety. Current physician's orders included Risperdal 1 mg-take 1 tablet 2 times a day for bipolar disorder. This order originated [DATE]. A [DATE], quarterly, Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired, had not displayed any signs of hallucinations or delusions during the assessment period, nor did they display any maladaptive behaviors during the assessment period. They received antipsychotic and antidepressant medications during the assessment period. A [DATE], pharmacy Psychotropic & Sedative/Hypnotic Utilization By Resident report indicated Resident 6 received Risperdal 1 mg two times daily. She had received the medication since [DATE] and had never had a gradual dose reduction. A [DATE], Psychiatry Progress note indicated: The resident had trouble falling asleep and staying asleep at night. The resident frequently slept during the day. The resident denied depression, anxiety, self-harm, suicidal thoughts or suicidal ideations. The resident described her mood as stable and denied feelings of hopelessness or helplessness. She was alert, calm, and cooperative throughout the evaluation. Nursing staff report no further concerns at this time.The resident clinical record lacked an identified targeted behavior for the use of the antipsychotic medication Risperdal. The clinical record lacked documented delusions, hallucinations, or maladaptive behaviors which negatively impacted quality of life or quality of care during the past three-month period. The clinical record lacked a care plan related to targeted behaviors being treated by antipsychotic medication. During an observation on [DATE] at 11:07 a.m., Resident 6 was in her room. She was calm.During an observation on [DATE] at 12:15 p.m., the resident was calmly eating lunch.During an observation on [DATE] at 9:48 a.m., the resident was watching TV in her room. She was alert and well groomed. She was calm and conversational. During an interview on [DATE] at 2:42 p.m., CNA 13 indicated Resident 6 was forgetful and had once had a false belief that her son had died. She did not display behaviors that negatively impacted her quality of life or quality of care.During an interview on [DATE] at 2:46 p.m., QMA 14 indicated she had not observed the resident display any hallucination or delusions. The resident did at times mother other residents.During an interview on [DATE] at 2:51 p.m., RN 15 indicated the resident did not display delusions or hallucinations. She, at times, would try to give directions to other residents. 3. Resident 7's clinical record was reviewed on [DATE] at 3:20 p.m. Current diagnoses included delusional disorder, adjustment disorder, unspecified intellectual (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disability, anxiety, and dementia. Current physician orders included Seroquel (antipsychotic medication) 75 mg- 1 tablet daily at bedtime. This order originated [DATE]. A [DATE], modified annual, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, had not displayed any signs of hallucinations or delusions during the assessment period, nor did they display any maladaptive behaviors during the assessment period. They received antipsychotic and antianxiety medications during the assessment. The resident had one behavior note in the past three-month period (October to survey date) as follows: A [DATE] at 1 :56 p.m., Behavior Note-Late Entry indicated the nurse noticed the resident crying in the hallway. When approached, the resident stated Them guys are going in all the rooms and I'm scared. Can I move? The nurse attempted to console the resident and she appeared to calm down easily. The nurse assured the resident that she was safe and assisted her to find a seat near someone she was familiar with. She no longer appeared to be upset. A [DATE] pharmacy Psychotropic & Sedative/Hypnotic Utilization By Resident report indicated: Resident 7 received Seroquel 75 mg at bedtime. She had received the medication since [DATE] and had never had a gradual dose reduction of this medication.A [DATE] Psychiatry Progress Note indicated the resident denied depression, anxiety, hallucinations, delusions, suicidal ideation, homicidal ideation, or thoughts of self-harm. Nursing staff reported full medication compliance with no observed or reported side effects. The patient appeared alert, calm, and cooperative throughout the evaluation.The resident's clinical record lacked an identified targeted behavior for the use of the antipsychotic medication Seroquel. The clinical record lacked documented delusions, hallucinations, or maladaptive behaviors which negatively impacted quality of life or quality of care during the past three-month period. The clinical record lacked a care plan related to targeted behaviors being treated by the antipsychotic medication. During an observation on [DATE] at 11:06 a.m., Resident 7 was walking in the hallway and spoke to staff, visitors, and peers.During an observation on [DATE] at 12:05 p.m., the resident was calmly eating lunch. During an observation on [DATE] at 9:44 a.m., the resident was attending an activity. She was calm and smiling. During an interview on [DATE] at 2:42 p.m., CNA 13 indicated Resident 7 was tearful at times and stated she was lonely.During an interview on [DATE] at 2:46 p.m., QMA 14 indicated she had never witnessed the resident having delusions or hallucinations. The resident did cry at times.During an interview on [DATE] at 2:51 p.m., RN 15 indicated the resident used to cry, but didn't cry much anymore. She had never witnessed the resident having delusions or hallucinations. During an interview on [DATE] at 10:40 a.m., the Corporate RN Consultant and Social Services Director indicated they would look for resident specific targeted behaviors for the use of antipsychotic medications for Residents 5, 6, and 7. They would also look for care plans related to said behaviors and any incidents of these behaviors being documented in the clinical record.During an interview on [DATE] at 3:20 p.m., the Administrator indicated Residents 5, 6, and 7 did not have documented targeted behavioral symptoms for the use of antipsychotic medications, nor did they have documented behaviors related to the use of antipsychotic medications, nor did they have care plans that addressed targeted behavioral symptoms being treated by an antipsychotic medication. A current, 2/2025, facility policy titled, Psychotropic Medication Use, provided by the ADON on [DATE] at 9:05 a.m., indicated Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior.Anti-psychotics;.Determining adequate indications for use;. the medication os determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record.A resident's behavioral symptoms present a danger to the resident or others; a resident is exhibiting indications of distress that are significant to the resident. 3.1-3(w)3.1-26(k)(1)(o)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to complete a thorough investigation of and maintain record of the investigation of resident-to-resident abuse for 2 of 3 residents reviewed for abuse. (Resident B and Resident 76)Findings include:Review of a facility investigation for a resident-to-resident altercation, on 12/18/25, between Resident B and Resident 76, and provided by the facility on 1/7/26 at 4:31 p.m., indicated it included the following information: A recapitulation of a facility reported incident that occurred on 12/18/25 at 8:20 p.m. with a brief description of the resident-to-resident altercation. Resident B accused roommate (Resident 76) of stealing clothing from his closet. Resident B was yelling for Resident 76 to get out of his closet. Type of Injury: None. Immediate Action Taken: The staff immediately separated the residents. The nurse completed skin assessments and neither of the residents had any issues identified. Resident 76 was moved to another room. The Administrator and DON were notified immediately of the incident. The provider and responsible parties were notified. Preventative Measures Taken: An investigation was initiated. The nurse completed skin assessment. Residents were separated. Resident 76 was moved to another room and both residents were placed on 15-minute safety checks. Both residents were to be seen by psychiatry on their next visit. Psychosocial monitoring will be provided, and plan of care will be reviewed and updated as needed. Interviews from Resident B and Resident 76. Three resident interviews regarding safety on a different unit. Fifteen-minute safety checks for Resident B and Resident 76. An Inservice Attendance dated 12/24/25 regarding Resident-to-Resident Abuse Reporting for 112 staff members. The facility investigation lacked the following information: any staff statements or interviews, the facility incident report and interviews with interviewable residents who were located near the room where the altercation occurred. During an interview, on 1/8/25 at 12:56 p.m., the Corporate Nurse Consultant indicated she noticed the facility investigation lacked any staff statements in the investigation after a copy was provided of the facility investigation. A second request was made to provide the entire facility investigation for the altercation on 12/18/25 between Resident B and Resident 76. On 1/8/25 at 2:21 p.m., the Corporate Nurse Consultant indicated she was unable to find the statements in the facility investigation, even though she had seen them before. During a telephone interview on 1/8/26 at 2:52 p.m., CNA 26 indicated she did not see the altercation between Resident B and Resident 76 on 12/18/25, but she was working on that Unit nearby when it occurred and heard the commotion. The other aides who were present on the Unit were CNA 25 and CNA 27. She indicated CNA 25, CNA 26 and CNA 27 wrote out individual statements and gave them to the nurse that night, but she was uncertain of which nurse they were given to. During an interview on 1/8/26 at 3:33 p.m., LPN 11 indicated he had not previously written a statement for the facility investigation of the altercation between Resident B and Resident 76 until today, when an unidentified Administration staff member came to him and asked him to write a statement. During a telephone interview on 1/8/26 at 11:17 p.m., CNA 25 indicated she was at the facility on 12/18/25 around approximately 8:15 p.m. when the resident-to-resident altercation occurred between Resident B and Resident 76. On 12/18/25 at approximately 8:30 p.m., CNA 25 called the DON and reported the altercation between the residents. The DON gave instructions to keep the residents separated, move Resident 76 to another room, and for CNA 25, CNA 26, and CNA 27 to complete written statements for the DON. On 12/18/25, CNA 25, CNA 26, and CNA 27 wrote out their statements and together placed their individual statements in the DON's mailbox with CNA 25's statement on top. No one had asked her to provide any further information.During a telephone interview on 1/8/25 at 11:41 p.m., LPN 28 indicated she was the nurse on shift for the 200 Unit following LPN 11 the night of 12/18/25 after the altercation occurred between Resident B and Resident 76. No one had provided any written statements to her regarding the altercation that happened prior to her shift. On 1/9/25 at 2:06 p.m., the Corporate Nurse Consultant indicated the following information was required to ensure a complete and thorough investigation of resident-to -resident abuse: face sheets and orders of residents (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involved, pertinent progress notes, an incident report of the event, skin assessments as needed, staff and resident witness statements of anyone who witnessed it audibly or visually, statement from the nurse on duty, resident interviews with interviewable residents that were in close proximity to where the incident occurred and ensuring their safety. All of the residents interviewed, outside of the involved residents, were on another Unit on the other side of the building. The investigation did not include interviewable resident near the room the altercation took place in. The entire facility investigation should have been kept securely and ready for review upon request. A current policy, revised 5/2024, titled Abuse Prevention, Identification, and Reporting Policy, provided by the Corporate Nurse Consultant on 1/7/26 at 4:31 p.m., indicated the following: Policy: To establish guidelines for preventing, identifying, and reporting abuse. These procedures shall include.investigation.without fear of recrimination or intimidation. COMPREHENSIVE CARE FACILITIES.(d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. Cross Reference F600. 3.1-28(d)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide residents and/or their representatives with written notice of transfer/discharge and bed hold policy for 3 of 4 residents reviewed for hospitalizations. (Residents 2, 56, and 43) Findings include: 1.Resident 2's record was reviewed on 1/7/26 at 10:11 a.m. Medical diagnoses included generalized anxiety disorder, epilepsy (seizure disorder), substance abuse, and complex regional pain syndrome. A quarterly minimum data set (MDS) completed on 12/2/25 indicated the resident was cognitively intact. A 9/8/25 nurse's note indicated the resident was sent to the emergency room following mental status changes and urinary tract infection (UTI) symptoms. The clinical record lacked indication the resident and/or representative was provided a notice of transfer/discharge form and bed hold policy. A 10/22/25 nurse's note indicated the resident was transferred to the emergency room after being found unresponsive. The clinical record lacked indication the resident and/or representative was provided notice of transfer/discharge form and bed hold policy. Review of notice of transfer/discharge forms and bed hold policy, dated 9/8/25 and 10/21/25, provided by the ADON on 1/8/26 at 2:48 p.m., indicated the resident was discharged to the hospital. The documents did not indicate the resident or resident representative were provided the notices. The forms lacked documentation of who received the paperwork. 2.Resident 56's clinical record was reviewed on 1/7/26 at 10/28 a.m. Diagnoses included COPD, neurofibromatosis (a genetic disorder causing tumors), and epilepsy. A 12/30/25, significant change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A 12/19/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 12/19/25, progress note indicated the resident was sent to the emergency room for a displaced nephrostomy tube (to drain urine from the kidney). A 9/9/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 9/9/25, progress note in the resident's family requested they be sent to the emergency room for altered mental status. The clinical record lacked indication the resident and/or representative was provided a copy of the transfer/discharge form and bed hold policy. Review of notice of transfer/discharge forms and bed hold policy, dated 12/19/25 and 9/9/25, (continued on next page)

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	155400	A. Building B. Wing	01/09/2026

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided by the ADON on 1/8/26 at 2:48 p.m., indicated the resident was discharged to the hospital. The documents did not indicate the resident or resident representative were provided the notices. The forms lacked documentation of who received the paperwork. 3. Resident 43's clinical record was reviewed on 1/6/26 at 2:44 p.m. Diagnoses included unspecified anemia, benign prostratic hyperplasia with lower urinary tract symptoms, and borderline personality disorder. A 12/4/25, quarterly MDS assessment indicated the resident was cognitively intact. A 12/12/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 12/12/25, progress note indicated the resident was difficult to awaken and had an altered mental status. The Nurse Practitioner (NP) provided an order to send the resident to the emergency room. The resident's medication list, bed hold, face sheet and code status were sent with the Emergency Medical Technicians (EMTs). The clinical record lacked indication the resident and/or representative was provided a copy of the transfer/discharge form and bed hold policy. A 11/17/25, discharge MDS assessment indicated the resident discharged with a return anticipated. A 11/17/25, eInteract observation note indicated the resident was discharged to the hospital with bloody drainage in his catheter bag. A 11/17/25, progress note indicated the resident had increased temperature and was clammy. The NP provided an order to send the resident to the emergency room. Paperwork sent and message left for the residents friend. The clinical record lacked indication the resident and/or representative was provided a copy of the transfer/discharge form and bed hold policy. Review of the notice of transfer/discharge forms and bed hold policy, dated 12/12/25 and 11/17/25, provided by the ADON on 1/8/26 at 2:48 p.m., indicated the resident was discharged to the hospital. The documents did not indicate the resident or resident representative were provided the notices. The forms lacked documentation of who received the paperwork. During a 1/8/26 interview LPN 7 indicated residents were sent out with a face sheet, medication order summary, bed hold policy, and a change of condition form. The forms were given to emergency medical services (EMS). During a 1/8/26 interview QMA 10 indicated a face sheet, medication orders, advance directive, and bed hold policy were given to EMS whenever a resident was sent out. During a 1/9/26 interview, the ADON indicated residents were sent out with a face sheet, order summary, and a physician's order for scope of treatment (POST) form indicating their code status. The documents sent were then documented in a progress note. A current undated facility policy, titled, Your Right and Protections as a Nursing Home Resident, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided by the ADON on 1/9/26 indicated the following: .The nursing home has to safely and orderly transfer or discharge you and give you proper notice of bed-hold and/or readmission requirements.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure timely completion of a required Level 2 Preadmission Screening and Resident Review (PASARR) assessment for 1 of 2 residents reviewed for PASARR. (Resident 8) Findings include:Resident 8's clinical record was reviewed on 1/7/26 at 10:16 a.m. She admitted to the facility on [DATE] and remained in the facility. Diagnoses included delusional disorders, generalized anxiety disorder, unspecified psychosis not due to a substance of known physiological condition, unspecified visual disturbances, and unspecified vascular dementia. A 3/13/25, Notice of Level I PASARR Screen Outcome, indicated the referral for a Level 2 onsite for suspected mental health disability. The clinical record lacked documentation of a completed Notice of Level 2 PASSAR Screen Outcome. During an interview, on 1/8/26 at 10:30 a.m., the SSD indicated she started her position with the facility in November. She utilized the Maximus Assessment Pro online system, and the Level 2 for this resident was cancelled. She indicated the resident's Level Of Care determination letter indicated an approval for indefinite long term nursing care. The SSD indicated she thought the Level Of Care determination meant that the Level 1 and/or Level 2 was not needed. She spoke with a customer service representative specializing in these assessments and was informed that the facility should have either completed the onsite Level 2 or restarted with a new Level 1 screening process. During an interview, on 1/8/26 at 4:25 p.m., the Corporate Nurse Consultant indicated the facility did not have a policy related to PASSAR screenings. According to the Medicaid website page, Preadmission Screening and Resident Review, found at https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-scre retrieved on 1/12/25 at 12:57 p.m., indicated the following: .Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that Medicaid-certified nursing facilities: 1. Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID) .In brief, the PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a Level I screen. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care .3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to invite the resident representative to the resident's care plan meeting, offering them the opportunity to engage/contribute to the resident's admission care plan meeting for 1 of 2 residents reviewed for care planning. (Resident 11) Finding includes:During an interview on 1/6/26 at 10:55 a.m., Resident 11 indicated he had not been included in a care plan meeting. He had an appointed guardian and did not know if the guardian was invited to the care plan meeting. Resident 11's clinical record was reviewed on 1/6/26 at 2:44 p.m. Diagnoses included schizophrenia, atrial fibrillation, pulmonary embolism with acute cor pulmonale, Parkinson's Disease with dyskinesia, encephalopathy, and rhabdomyolysis. An 11/19/25, admission Minimum Data Set assessment indicated the resident was cognitively intact. Active diagnoses included schizophrenia, Parkinson's Disease, atrial fibrillation, pulmonary embolism, respiratory failure, and heart failure. Guardianship papers were in place for the resident. The clinical record lacked documentation of an invitation for the resident's representative to attend the care plan meeting. A 12/4/25, admission Care Conference was held and indicated the resident was in attendance. The resident representative was not in attendance. The care plan conference document indicated to add a reason if the resident representative was not in attendance. A reason was not provided. During a telephone interview on 1/9/26 at 11:07 a.m., the Resident 11's Representative indicated the resident had been at the facility since November following a long hospitalization. The representative had not been invited by the facility to attend any care plan meetings for the resident. On 1/9/26 at 11:21 a.m., the Social Services Director indicated they typically placed resident representative invitations to care plan meetings in a binder or in the progress notes of the resident's electronic record. She indicated she could not provide any information regarding an invitation for Resident 11's representative to attend his care plan meeting. On 1/9/26 at 2:00 p.m., the Corporate Nurse Consultant indicated residents should have their rights honored and both the resident and their representative should have been invited to participate in the resident's care plan meetings. They followed the State and Federal guidelines regarding resident rights. A current facility policy, dated March 2022, titled Care Plans, Comprehensive Person-Centered, provided by the ADON on 1/9/26 at 2:10 p.m., indicated the following: .Policy interpretation and implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process. 6. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. 3.1-35(c)(2)(C)

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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. Based on observation, record review, and interview, the facility failed to provide necessary services for a resident related to humidification for high-flow rate oxygen for 1 of 2 residents reviewed for oxygen administration. (Resident 56) Findings include:During an obseration and interview, on 1/5/26 at 12:02 p.m., Resident 56 was lying in a specialty bed against the wall. The resident was wearing a nasal cannula for oxygen administration. She indicated she wore oxygen consistently and her oxygen setting was 5 liters per minute. The oxygen concentrator was positioned at bedside and was set for 5 liters per minute. The water humidification container was empty. The inside of the container was covered in a white film. The container was dated 11/25 in black marker. On 1/6/26 at 10:32 a.m., Resident 56 was lying in bed wearing a nasal cannula. The oxygen concentrator was positioned at bedside and was set for 4 liters per minute. The water humidification container was empty. The inside of the container was covered in a white film. The container was dated 11/25 in black marker. On 1/7/26 at 9:46 a.m., Resident 56 was lying in bed wearing a nasal cannula. The oxygen concentrator was positioned at bedside and was set for 5 liters per minute. The water humidification container was empty. The inside of the container was covered in a white film. The container was dated 11/25 in black marker. The resident indicated the staff didn't check the oxygen concentrator set up often. On 1/8/26 at 11:07 a.m., Resident 56 was lying in bed wearing a nasal cannula. The oxygen concentrator was positioned at bedside and was set for 5 liters per minute. The water humidification container was empty. The inside of the container was covered in a white film. The container was dated 11/25 in black marker. Resident 56's clinical record was reviewed on 1/7/26 at 10/28 a.m. Diagnoses included COPD, neurofibromatosis (a genetic disorder causing tumors), and epilepsy. Current orders included continuous oxygen 3-5 liters per minute via nasal cannula for COPD (6/10/25) and change and date oxygen and tubing, water bottle, and bag every Sunday on night shift (9/18/25). A 6/11/25, respiratory care plan indicated the resident had COPD related to smoking and had chronic respiratory failure. Interventions included to elevated the head of the bed to prevent shortness of breath while lying (6/11/25), give aerosol and bronchodilators as ordered (6/11/25), and oxygen per physician orders (6/11/25). A 12/30/25, significant change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and required oxygen therapy. During an observation and interview, on 1/8/26 at 11:24 a.m., LPN 9 indicated when a resident on her assignment had oxygen orders, she would check their oxygen saturation level (SpO2) and the liters per minute level on the concentrator. The staff should check the oxygen level and water container level on each shift. LPN 9 confirmed Resident 56's water container was completely empty and dated 11/25 in black marker. Any resident utilizing oxygen without water might experience dry sinuses which could lead to nose bleeds and discomfort. During an interview, on 1/9/26 at 1:35 p.m., the Corporate Nurse Consultant indicated the expectation for nursing staff was to assess each resident utilizing oxygen on each shift. The assessment should include confirming the oxygen equipment was set appropriately and working properly. The staff should assess the water level as well. A resident receiving oxygen without proper water humidification might experience dried mucus membranes which could lead to irritation, discomfort, and even nose bleeds. She indicated there was no additional facility policy related to oxygen administration to provide. A current facility policy, revised 11/14, titled, Medication Orders, provided by the DON on 1/8/26 at 2:48 p.m., indicated the following: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders . 3. Oxygen Orders- When recording orders for oxygen, specify the rate of flow, level and rationale .3.1-47(a)(6)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies regarding Drug Labeling/Storage. Finding includes:Review of the Summary Statement of Deficiencies for the facility's last annual recertification and licensure survey, completed on 12/17/24, indicated the facility had deficiencies related to unlabeled medications.During an interview, on 1/9/26 at 4:03 p.m. the ADON indicated the Quality Assessment and Assurance (QAA) committee met each morning and monthly to discuss current facility concerns. The current nursing topics were falls. The ADON indicated the facility had weekly audits in place for medication carts. The current QAPI binder for the facility was reviewed on 1/9/26 at 4:26 p.m. The binder lacked any audits for repeat deficiencies.Repeat concerns regarding medication storage/labeling were cited during the 1/5/26 survey as follows:Based on observation and interview, the facility failed to store medications according to professional standards relating to unlabeled medications for 2 of 4 medication carts reviewed. (100 East and 100 West)A current undated untitled facility policy, provided by the ADON on 1/9/26 at 4:47 p.m. indicated the following: .The committee will identify opportunities for improvement, address break down in systems or processes, develop and implement an improvement or corrective action plan and continuously monitor effectiveness of interventions at each monthly meeting.4. Department Directors will implement Action Plan that identifies trends and Root Cause Analysis and guide systematic changes for their areas needing improvement. These should be reviewed and presented during the QAPI meeting. 5. Each department will complete their monthly Quality Assurance Tools per calendar or as indicated per direction of the Executive Director and calculation of percentages will be completed to evaluate areas of opportunity.Cross reference F761.3.1-52(b)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to implement the appropriate infection control precautions related to transmission based precautions per the Centers for Disease Control and Prevention (CDC) guidelines for 1 of 2 residents reviewed for infection control. (Resident 43)Findings include:During an observation, on 1/5/26 at 10:10 a.m., Resident 43's door was closed, and an orange Enhanced Barrier Precautions (EBP) sign was present. There was a yellow organizer hanging from the door with Personal Protective Equipment (PPE) available.During an interview, at the time of the observation, LPN 9 indicated the resident had an infection in his urine and he had a catheter. She wore a gown, gloves, and mask for all care. She thought the resident's infection was Candida Auris (C. Auris) and the isolation sign on the door was not the correct isolation precaution.During an observation and interview, on 1/7/25 at 9:59 a.m., Laundry Aide 20 delivered clean laundry to Resident 43's room. Laundry Aide 20 was wearing a surgical face mask. He knocked on the resident's door and entered the room without donning additional PPE. The orange EBP precaution sign and yellow organizer with PPE were hanging on the door. Laundry Aide 20 completed hand hygiene as he exited the room. He indicated he always wore a surgical face mask for personal preference. The precaution signs on some of the residents' doors were to let the nursing staff know which residents were sick and when to wear PPE.Resident 43's clinical record was reviewed on 1/6/26 at 2:44 p.m. Diagnoses included unspecified anemia, benign prostatic hyperplasia with lower urinary tract symptoms, and borderline personality disorder. A 12/4/25, quarterly, MDS assessment indicated the resident was cognitively intact and required total staff assistance for all Activities of Daily Living (ADLs), except for eating meals.Current order included strict isolation - Contact Isolation. All therapies, meals, and activities to be provided in room every shift- every shift (12/30/25).A current isolation care plan, dated 12/30/25, indicated the resident was in isolation for observation for signs and symptoms of Candidozyma Auris (fungi). Interventions included droplet yellow isolation (12/30/25), administer medications per physicians orders (12/30/25), all services in room such as meals, activities, and all ADL care (12/30/25, and notify physician as needed for complications that may be cause by C. Auris such as fever, chills, sweats, low blood pressure, high heart rate, pain, and wound infections (12/30/25).A 1/6/26, progress note indicated the resident continued on isolation per protocol for C. Auris.A 1/5/26, progress note indicated the resident continued on isolation per protocol for C. Auris.A 1/2/26, progress note indicated the resident was in good spirits, resting in bed, and continues on isolation.A 12/30/2025, progress note indicated the resident remains in Strict Isolation/Candida Auris- Contact Isolation. All therapies, meals, and activities to be provided in room every shift.During an interview, on 1/7/26, at 2:51 p.m., CNA 21 indicated when she provided care for Resident 43, she donned a gown, gloves, and a face mask. The resident was in isolation for an infection and the EBP sign and PPE hanging on his door let the staff know what to put on before entering his room. She would ask a nurse to find out the specific infection the resident had.On 1/8/26 at 11:02 a.m., Housekeeper 22 indicated when a room on her assignment has the orange EBP sign, like Resident 43's room, she wears the PPE hanging on the door to clean his room. The signs let staff know which residents have infections and what protective gear to wear. The housekeeping manager lets the housekeeping staff know which rooms require special cleaning chemicals like bleach.On 1/8/26 at 11:12 a.m., CNA 23 indicated she was unsure of the difference between EBP and Contact Isolation. The orange EBP sign on Resident 43's door means she needs to wear gowns, gloves, and a face mask because the resident has an infection. She would ask the nurses if she needed to know which infection the resident had.On 1/8/25 at 11:14 a.m., LPN 9 indicated the EBP sign means the staff needs to wear a gown, gloves, and mask for all resident care. Contact isolation means the staff have to wear all PPE to have contact with the residents. She indicated the sign on Resident 43's door was wrong and should be a Contact isolation sign since he had a C. Auris infection. Residents with C. Auris infections need to remain in their rooms at all times to prevent the spread of infection. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents get meals, activities, and therapy in their room.On 1/8/25 at 11:45 a.m., LPN 7 indicated the EBP sign means a resident is in isolation and the staff need to wear a gown and gloves before entering the resident room to complete patient care. She thought this was the same as Contact isolation. The isolation precautions help protect the residents and staff from the spread of any infection.During a telephone interview, on 1/8/26 at 3:31 p.m., the Infection Preventionist indicated Resident 43 was in EBP's due to his catheter. She was contacted by the health department and told of the diagnoses after his arrival. He had returned to the facility with an infection, C. Auris. He was in EBP, and she thought this was appropriate. She was contacted by the Corporate Nurse Consultant today and advised the CDC recommendations require residents with C. Auris be in Contact Isolation and not just EBP.During an interview, on 1/9/26 at 11:00 a.m., the Housekeeping Manager indicated the laundry and housekeeping staff are required to follow any precautions or isolation signs on the resident's door. The EBP and Contact isolation signs require wearing a gown and gloves before providing patient care. The resident's laundry was to be placed in special yellow or red plastic bags for transportation to the laundry room.On 1/9/26 at 1:40 p.m., the Corporate Nurse Consultant indicated the facility was unaware of testing Resident 43 received prior to returning to the facility. A few days after the resident's return, the Infection Preventionist was contacted by the health department and told that the resident had tested positive for C. Auris. The swab testing sites were in the groin and axilla areas. The resident had been in EBP due to his catheter and should have been moved into Contact Isolation per the CDC guidelines. EBP requires staff to don a gown and gloves before providing patient care for someone with a catheter, wound, or PICC line. Contact Isolation required staff to don a gown, gloves, and mask prior to entering the resident's room to prevent spread of infection from the resident and the resident's environment. Resident 43 required Contact Isolation Precautions instead of the EBP.A current facility policy, revised 9/22, titled, Isolation- Categories of Transmission-Based Precautions, provided by the ADON on 1/9/25 at 9:04 a.m., indicated the following: . 1. Contact precautions are implemented for resident known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment . 3. Contact precautions are used for residents infected or colonized with MDRO's in the following situations: a. When a resident has wounds, secretions, or excrections that are unable to be covered of contained .7. Staff and visitors wear gloves (clean, non-sterile) when entering the room .8. Staff and visitors wear a disposible gown upon entering the room .3.1-18(a)(2)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to offer and administer appropriate Pneumococcal vaccinations per the Center for Disease and Control (CDC) guidance for 3 of 5 residents reviewed for infection control. (Residents 56, 61, and 8)Findings include: 1. Resident 56's clinical record was reviewed on 1/7/26 at 11:41 a.m. Diagnoses included COPD (chronic obstructive pulmonary disease), neurofibromatosis (a genetic disorder causing tumors), and epilepsy. A 12/30/25, significant change, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. Review of the resident's vaccinations included the following:The resident had a historical administration of an unspecified pneumococcal vaccination on 12/21/23, prior to admission to the facility.The clinical record lacked a Pneumococcal Vaccine Consent or Declination Form.The clinical record lacked any offerings of the Pneumococcal vaccine. 2. Resident 61's clinical record was reviewed on 1/7/26 at 1:46 p.m. Diagnoses included schizophrenia, type 2 diabetes mellitus, and hypertension.A 10/28/25, quarterly, MDS assessment indicated the resident was cognitively intact. Review of the resident's vaccinations included the following:The resident had a historical administration of an unspecified pneumococcal vaccination on 5/19/16, prior to admission to the facility. The resident also had a historical administration of an unspecified pneumococcal vaccination on 12/21/23, after admission to the facility. The clinical record lacked a Pneumococcal Vaccine Consent or Declination Form.The clinical record lacked any additional offerings of the Pneumococcal vaccine since 2023.3. Resident 8's clinical record was reviewed on 1/8/26 at 9:42 a.m. Diagnoses included generalized anxiety disorder, unspecified cerebral infarction (stroke), and delusional disorders.A 12/19/25, quarterly MDS assessment indicated the resident was cognitively intact. Review of the resident's vaccinations included the following:The clinical record lacked any historical pneumococcal vaccination information.The clinical record lacked a Pneumococcal Vaccine Consent or Declination Form.The clinical record lacked any offerings of the Pneumococcal vaccine. During a telephone interview, on 1/9/26 at 11:27 a.m., the Infection Preventionist indicated she reviewed new admission paperwork to find as much vaccination information as possible. The admission paperwork did not always contain vaccination information. The resident and resident representatives weren't always familiar with their vaccination history. Any information found was documented under the immunizations tab in the electronic medical record. The facility utilized consent and declination forms for all vaccinations and these documents were uploaded to the resident's chart. She took over this task earlier this year and reviewed vaccinations at the start of the current flu season. Residents 56, 61, and 8 should have been offered the appropriate Pneumococcal vaccination per the Centers of Disease Control and Prevention (CDC) guidelines. A current facility policy, revised 8/25, titled, Pneumococcal Vaccine, provided by the ADON on 1/8/26 at 2:49 p.m., indicated the following: 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series . 4. Provision of information, education, and the VIS are documented in the resident's medical record .3.1-18(b)(5)