

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G392	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 308 W MAIN ST SILVER LAKE, IN 46982
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W000000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Survey dates: 1/22, 1/23, 1/26, 1/27, and 1/28/2015.</p> <p>Provider Number: 15G392 Facility Number: 000906 AIM Number: 100235160</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/6/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 1 of 7 clients (client #2), the governing body failed to develop a written facility policy and procedure to ensure client #2's physical status was documented and monitored before/after aggressive behaviors and before/after</p>	W000104	<p><b>W104</b></p> <p>The governing body must exercise general policy, budget, and operating direction over the</p>	02/20/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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	<p>hospital admissions in client #2's record.</p> <p>Findings include:</p> <p>Please refer to W149. The governing body failed to ensure client #2's injuries of unknown source were immediately reported according to state law and to ensure client #2's physical status before/after aggressive behaviors and before/after hospital admissions was documented in client #2's record. The governing body failed to develop policies and procedures to document injuries of unknown source for client #2 after hospital admissions.</p> <p>9-3-1(a)</p>		<p>facility.</p> <p>Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served this includes but is not limited to documenting the physical status of an individual before/after aggressive behaviors and before/after hospital admissions.</p> <p>The facility has updated the LOA procedures and training was provided to the Residential Manager and to all Direct Support Staff working in the home on 2/13/15 (see attachment A). All Residential Managers and Direct Support Staff within the company will receive training by 2/27/15. Additionally the Residential Manager and all Direct Support Professionals working in the home received training on injury of unknown source/unobserved injuries on 2/13/15 (see attachment B).</p> <p>To ensure this deficiency does not occur again the Residential Manager will review LOA</p>		

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W000111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Based on record review and interview, for 1 additional client (client #6), the facility failed to ensure the staff recorded the use of the Heimlich Maneuver (used to intervene during choking episodes) and client #6's medical interventions after staff administered the Heimlich Maneuver in client #6's record.</p> <p>Findings include:</p> <p>On 1/22/15 at 1:45pm, the facility's</p>	W000111	<p>paperwork for thoroughness and accuracy to ensure that all injuries of unknown source have been accurately documented and reported per BDDS reporting guidelines.</p> <p><b>Residential Manager, Residential Nurse, and Coordinator responsible.</b></p> <p>W111</p> <p>The facility must develop and maintain a record keeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Cardinal Services Inc. is committed</p>	02/20/2015

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	<p>BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for client #6.</p> <p>-A 9/22/14 BDDS report for an incident on 9/22/14 at 6:15pm indicated client #6 choked at the dining room table during supper. The report indicated client #6 "was eating dinner when she started to choke on her potatoes. She started to turn red and staff asked her if she was choking and she did not answer. [Client #6] was asked if she could cough and when she coughed parts of her potato had come out of her mouth. She could no longer cough and staff had to give [client #6] the Heimlich maneuver. She then vomited up the rest of her potatoes and took a drink. She reported she was fine shortly after." The report did not indicate if the staff sought medical intervention after the Heimlich was used for client #6 from a qualified medical professional.</p> <p>Client #6's record was reviewed on 1/26/15 at 10:15am. Client #6's 5/21/2013 ISP (Individual Support Plan) indicated she was on a regular diet and she was encouraged to drink between bite size bites of food. Client #6's 9/23/14 "Dysphagia/Choking Plan" indicated client #6 "often takes large bites of foods...Food should be cut into less than bite sized pieces. It should be cut into</p>		<p>to ensuring the safety, dignity, and protection of persons served this includes but is not limited to monitoring an individual for signs/symptoms of aspiration after a choking incident has occurred.</p> <p>The facility has updated the Med Manual to reflect action/treatment necessary when the Heimlich has been performed (see attachment P). All Direct Support Staff working in the Adult Services program were made aware of these changes via an Adult Services memo on 2/12/15 (see attachment C). The Residential Manager and all Direct Support Staff working in the home received additional training on the updated procedures for the Heimlich maneuver on 2/13/15 (see attachment D).</p> <p>To ensure this deficiency does not occur again the Residential Manager will prompt staff to implement the aspiration tracking immediately in the event that a choking incident occurs. The Residential Manager will review the aspiration tracking after a choking incident occurs to ensure completion and thoroughness before sending to the Residential Nurse.</p> <p><b>Residential Manager and</b></p>				

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	<p>1/2" x (by) 1/2" x 1/2" pieces...Often [client #6] eats too quickly and does not chew thoroughly. [Client #6] should be encouraged to slow down, take a drink in between bites and pause. Encourage to chew food well before swallowing..."</p> <p>Client #6's 9/22/14 "Nurses Note" indicated "9/22 staff reports client choked and required the Heimlich. Writer instructs staff to call EMS (Emergency Medical Services) for evaluation of lung sounds. Staff are instructed to monitor vital signs. (signed by the agency nurse)." Client #6's record indicated her vital signs were taken once after the incident and once before bedtime. Client #6's record indicated a 9/22/14 "EMS...Patient Refusal of Services Form" which indicated EMS personnel was at the group home at "1900 (military time)" or 7:00pm. The EMS refusal form was signed by the staff on duty and indicated client #6 refused to be transported to the hospital.</p> <p>On 1/27/15 at 4:58pm, the RC provided emails regarding client #6's 9/22/14 choking incident which were not contained within client #6's record: -A 9/23/14 e-mail from the Residential Manager (RM) indicated "EMT were called to check [client #6] out afterwards and staff was told everything was fine with [client #6]."</p>		<b>Residential Nurse responsible.</b>				

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	<p>-A 9/22/14 e-mail from GHS #3 indicated vital signs "after incident: BP (Blood Pressure) 123/87, Pulse 59, and Temp: 96.2. Before bed: BP: 112/64, Pulse: 53, Temp: 96.4."</p> <p>-A 9/23/14 e-mail from the Adult Services Director (ASD) indicated "What is our protocol for medical follow up after the Heimlich is used on someone? I had it in my head that immediate medical attention was required. This incident doesn't state that any medical attention was given afterward."</p> <p>On 1/27/15 at 4:58pm, an interview with the RC was conducted. The RC indicated client #6's vital signs were monitored by the facility staff after the incident and before client #6 went to bed. The RC indicated 9-1-1 was called, the EMTs arrived, and evaluated client #6. The RC stated "The EMTs reported that they did not hear anything when they listened to [client #6's] lungs and that they did not deem it necessary for [client #6] to go to the emergency room. They further (verbally) instructed the staff on duty to call 9-1-1 if [client #6] began experiencing issues with her breathing or vomiting. [Client #6] did not display any of these signs through the night or following day." The RC indicated the email communications were not incorporated into client #6's record to</p>						

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W000149	<p>further monitor client #6 after the choking incident.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview for 1 of 7 clients (client #2), the facility neglected to ensure client #2's injuries of unknown source were immediately reported according to state law and to ensure client #2's physical status before/after aggressive behaviors and before/after hospital admissions was documented in client #2's record. The facility neglected to develop policies and procedures to document injuries of unknown source for client #2 after hospital admissions.</p> <p>Findings include:</p> <p>On 1/22/15 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for client #2 and did not include any reports of bruises or bodily injuries.</p>	W000149	<p><b>W149</b></p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>The facility has updated the LOA procedures and training was provided to the Residential Manager and to all Direct Support Staff working in the home on 2/13/15 (see attachment A). All Residential Managers and Direct Support Staff within the company will receive training by 2/27/15. Additionally the Residential Manager and all Direct Support Professionals working in the home received training on injury of</p>	02/20/2015

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	<p>On 1/22/15 from 4:05pm until 6:15pm, observation and interviews were completed at the group home with client #2. At 4:05pm, GHS (Group Home Staff) #1 indicated client #2 had returned home from the hospital around noon. At 4:05pm, client #2 was observed with a black right eye. Client #2's eye had black, green, brown, and yellow colors around, above, and below the eye. At 4:05pm, GHS #1 and the RM (Residential Manager) both stated client #2 returned from the hospital inpatient unit 1/22/15 at "around noon" and had the black eye. At 4:05pm, client #2 sat in a recliner in the living room at the group home, extended her right hand and the RM stated both client #2's wrist and forearm had "more than three or four" yellow, green, brown, black, and gray bruises. At 5:15pm, the RM stated she (the RM) was called by the inpatient unit "on Tuesday or Wednesday" and was told by staff at the inpatient unit that client #2 "had fallen out of her wheel chair. The [inpatient unit staff] took [client #2] to the hospital the next day after the goose egg above her right eye had moved down to blacken [client #2's] right eye." The RM stated client #2 had "other bruises on her body." The RM indicated client #2 had self injurious behaviors of rubbing her foot on top of the opposite lower leg</p>		<p>unknown source/unobserved injuries on 2/13/15 (see attachment B). The Residential Manager and all Direct Support Staff working in the home received additional training on Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 2/13/15 (See Attachment E). Clients #2 and #1 Support Plans were amended to reflect transport needs on 2/17/15 (see attachments F, G). The QDP for the home received training on amending/updating person served support plans when changes are necessary on 2/17/15 (see attachment H).</p> <p>To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the implementation of all individualized plans and agency Policies through weekly, monthly and quarterly observations.</p> <p><b>QDP, Residential Manager and Residential Coordinator responsible.</b></p>				

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	<p>which caused injuries before being admitted to the hospital and during this hospital stay emergency personnel had to restrain client #2 while being admitted to the hospital. The RM indicated no documentation was available for review of client #2's SIB (self-injurious behaviors). The RM spoke to client #2, client #2 shifted in her seat, and moved her bruised hand to rub her lower leg. Client #2 moved her pant leg which exposed additional bruises on client #2's lower leg which were green, yellow, brown, and black in color. The RM stated there "were more than four" additional bruises. The RM stated client #2 had "bruises all over her." The RM indicated she did not have knowledge regarding client #2's bruises. The RM indicated no documentation was available for review from the hospital or from the group home which recorded the multiple unknown bruises on client #2's body or their source.</p> <p>On 1/23/15 from 5:50am until 7:55am, observation and interviews were conducted at the group home with client #2. At 6:50am, the RM indicated client #2 had been suspended from riding the workshop bus because of her physically aggressive behaviors. The RM indicated client #2 was hitting other clients, hurting herself, and hitting staff during the</p>			
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	<p>transition time from the group home, onto the workshop bus, and after the bus arrived at the workshop. From 7:35am until 7:55am, client #2 was at the group home. The RM indicated client #2 had stayed home from workshop since she returned from the hospital on 1/22/15.</p> <p>On 1/23/15 at 7:55am, the RM indicated no documentation was available for review for client #2's multiple unknown bruises on her body or their source.</p> <p>Client #2's record was reviewed on 1/23/15 at 9:35am. Client #2's 5/20/14 ISP (Individual Support Plan) and 5/20/14 SMP (Self Management Plan) did not indicate client #2 had identified behaviors during transition periods from the group home, on the workshop bus, and once arriving at the workshop. Client #2's SMP listed targeted behaviors which included, but were not limited to: Physical Aggression, Verbal Aggression, Inappropriate Touch, Depression, and Irritability. Client #2's record indicated client #2 had multiple physically aggressive behaviors during 10/2014, 11/2014, and 12/2014 during transports on the workshop bus, refusing to exit the workshop bus, and after getting off the workshop bus. Client #2's record indicated client #2 had been suspended because of physically aggressive</p>			

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	<p>behaviors from riding the workshop bus and was returned home by car on 12/30/14. Client #2's record did not document unknown bruises. Client #2's record did not indicate client #2 had bruises on her body and did not indicate she had self injurious behaviors.</p> <p>On 1/27/15 at 3:00pm, the Residential Coordinator (RC) provided client #2's 1/26/2015 "IDT (Interdisciplinary Team) notes" which indicated the following: -"Analyzing of data associated with reportable incidents." -"Developing and implementing a risk reduction plan to minimize potential for future incidents." -"The IDT met to review recent behavioral issues and also to discuss the recent incident from this past weekend on 1/25/15...[Client #2] had an ER (Emergency Room) visit on 12/30/14, during that time she had bloodwork completed and a CAT scan and then was transferred to [inpatient behavioral unit] due to being very combative with all staff and emergency personnel." The report indicated all results were within normal limits. "While at the inpatient unit, the doctor started [client #2] on Depakote 250mg (milligrams). Her sodium dropped and [client #2] was transferred back to the hospital." The report indicated once client #2's blood levels</p>			

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	<p>returned to normal client #2 was transferred back to the inpatient behavioral unit. Client #2 was released to the group home 1/8/15. Client #2's medications were changed again and client #2 became "stable" with her behaviors. On 1/18/15 client #2 was "readmitted back to the ER due to behavioral concerns" and client #2 was readmitted back to the behavior inpatient unit. No medication changes were made during her inpatient stay. On 1/22/15 client #2 returned to the group home from the inpatient unit. On 1/25/15 client #2 was taken by "ambulance due to behavioral concerns of seeming ok to throwing items and becoming combative, slurring speech, and throwing things in a matter of seconds." The IDT note indicated the ER could not identify a medical issue and client #2 was referred to the behavioral inpatient unit. The inpatient unit was unable to admit client #2 and client #2 was returned to the group home. The IDT note did not include evidence and discussion regarding Self Injurious Behaviors.</p> <p>On 1/26/15 at 1:30pm, and on 1/27/15 at 11:00am, client #2's written guidelines for staff to implement during transitional periods were requested from the Residential Coordinator (RC). No guidelines were available for review for</p>			

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	<p>clients #2.</p> <p>On 1/23/15 at 10:00am, an interview with the RC was conducted. The RC stated client #2 had been self injurious, tore up her wheel chair, threw objects, pulled her hair, scratched herself, and dropped to the ground/floor which "might" account for "some" of client #2's bruises. The RC indicated client #2 received the black eye at the hospital after a fall. When asked if there was any documentation available for review of client #2's bruises, the RC stated "No." The RC indicated there was not a BDDS report or documentation available for review which recorded the amount, type, and colors of the unknown bruises on client #2's body.</p> <p>On 1/26/15 at 1:30pm, the RC indicated she had obtained client #2's hospital summary which indicated client #2 had fallen out of her wheel chair during her stay and the result was a black eye. No further information was available for review. A copy of the information was requested but was not provided. The RC indicated no BDDS report or documentation was available for review of the amount, type, and colors of client #2's unknown bruises on her body.</p> <p>On 1/27/15 at 3:00pm, the RC provided client #2's undated hospital summary</p>			

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	<p>which indicated client #2 had fallen out of her wheel chair during her stay and the result was a black eye. The document from the hospital indicated multiple bruises covering client #2's arms, legs, torso, face, and neck. The RC indicated no BDDS report or documentation was available for review of the amount, type, and colors of client #2's unknown bruises on her body.</p> <p>On 1/27/15 at 3:00pm, the facility's 6/2013 "Procedure for Leaving Service Locations" was reviewed and did not indicate guidelines for assessing clients who return to the agency's care to monitor for abuse, neglect, mistreatment, or injuries of unknown source.</p> <p>On 1/27/15 at 4:58pm, an interview with the RC was conducted. The RC stated "At this time the policy/procedure does not specify to complete a physical body check when individuals return from a hospital stay. If bruising is observed by staff upon the return of an individual from a hospital stay or from LOA (Leave of Absence) with family it would be reported to the appropriate on call manager and an investigation for injury of unknown origin would be initiated...if it meets the BDDS reporting guidelines then an incident report is completed."</p>			

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	<p>On 1/28/15 at 9:45am, an interview with the Agency's Adult Services Director (ASD) was conducted. The ASD stated "No," the policy and procedures did not include documenting a client's physical status before/after hospital admissions.</p> <p>On 1/28/15 at 8:00pm, the Residential Coordinator indicated the agency updated and revised their policy and procedures and then provided a 1/2015 revision of the facility's 1/2015 "Physical Examination Form." The policy and procedure 1/2015 revision indicated "the Physical Examination Form should be completed prior to the individual leaving and immediately upon return, this includes hospital and inpatient stays outside of the Cardinal Facility. In the event of an emergency and there is no time to complete the physical examination (form) before leaving the home, staff will complete this physical examination immediately upon arriving to the emergency department."</p> <p>On 1/22/15 at 1:45 PM, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical,</p>						

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W000153	<p>verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."</p> <p>On 1/22/15 at 1:45 PM, the facility's 7/2012 "Incident/Abuse/Neglect Policy" was reviewed. The policy indicated "Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated (sic); incidents will be reported and thoroughly investigated as outlined in this policy...Reportable Incidents...All injuries of unknown origin and allegations of abuse, neglect, and mistreatment must be reported to the administrator immediately."</p> <p>9-3-2(a)</p>			
	483.420(d)(2)			

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	<p><b>STAFF TREATMENT OF CLIENTS</b></p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on observation, record review, and interview, for 1 of 7 clients (client #2), the facility failed to immediately report client #2's injuries of unknown source after a hospital admission to the Administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Findings include:</p> <p>On 1/22/15 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for client #2 and did not include any reports of bruises or bodily injuries.</p> <p>On 1/22/15 from 4:05pm until 6:15pm, observation and interviews were completed at the group home with client #2. At 4:05pm, GHS (Group Home Staff) #1 indicated client #2 had returned home from the hospital around noon. At 4:05pm, client #2 was observed with a black right eye. Client #2's eye had black, green, brown, and yellow colors around, above, and below the eye. At 4:05pm, GHS #1 and the RM</p>	W000153	<p><b>W153</b></p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to the other officials in accordance with State law through established procedures.</p> <p>Per Cardinal Services' "Incident/Abuse/Neglect Policy Persons Served" Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served. The Residential Manager and all Direct Support Staff working in the home received training on injury of unknown source/unobserved injuries on 2/13/15 (see attachment B). The facility has updated the LOA procedures and training was provided to the Residential Manager and to all Direct Support Staff working in the home on 2/13/15 (see attachment A). All Residential Managers and Direct Support Staff</p>	02/20/2015

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	(Residential Manager) both stated client #2 returned from the hospital inpatient unit 1/22/15 at "around noon" and had the black eye. At 4:05pm, client #2 sat in a recliner in the living room at the group home, extended her right hand and the RM stated both client #2's wrist and forearm had "more than three or four" yellow, green, brown, black, and gray bruises. At 5:15pm, the RM stated she (the RM) was called by the inpatient unit "on Tuesday or Wednesday" and told by staff at the inpatient unit that client #2 "had fallen out of her wheel chair, the [inpatient unit staff] took [client #2] to the hospital the next day after the goose egg above her right eye had moved down to blacken [client #2's] right eye." The RM stated client #2 had "other bruises on her body." The RM indicated client #2 had self injurious behaviors of taking one foot and rubbing it on the lower opposite leg before being admitted to the hospital and during this hospital stay emergency personnel had to restrain client #2 while being admitted to the hospital. The RM spoke to client #2, client #2 shifted in her seat, and moved her bruised hand to rub her lower leg. Client #2 moved her pant leg which exposed additional bruises on client #2's lower leg which were green, yellow, brown, and black in color. The RM stated client #2 had "more than four" additional bruises. The RM stated client		within the company will receive training by 2/27/15.  To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the implementation of all individualized plans and agency Policies through weekly, monthly and quarterly observations.  <b>Residential Manager, Residential Nurse and Residential Coordinator responsible</b>	

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	<p>#2 had "bruises all over her." The RM indicated she did not have knowledge regarding client #2's bruises. The RM indicated no behavior data sheets and no documentation was available for review from the hospital or from the group home which recorded the multiple unknown bruises on client #2's body or their source.</p> <p>On 1/23/15 at 7:55am, the RM indicated no documentation was available for review for client #2's multiple unknown bruises on her body or their source.</p> <p>On 1/27/15 at 3:00pm, the Residential Coordinator (RC) provided client #2's 1/26/2015 "IDT (Interdisciplinary Team) notes" which indicated the following: -"The IDT met to review recent behavioral issues and also to discuss the recent incident from this past weekend on 1/25/15...[Client #2] had an ER (Emergency Room) visit on 12/30/14, during that time she had bloodwork completed and a CAT scan and then was transferred to [inpatient behavioral unit] due to being very combative with all staff and emergency personnel." The report indicated all results were within normal limits. "While at the inpatient unit, the doctor started [client #2] on Depakote 250mg (milligrams). Her sodium dropped and [client #2] was transferred</p>			
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	<p>back to the hospital." The report indicated once client #2's blood levels returned to normal client #2 was transferred back to the inpatient behavioral unit. Client #2 was released to the group home 1/8/15. Client #2's medications were changed again and client #2 became "stable" with her behaviors. On 1/18/15 client #2 was "readmitted back to the ER due to behavioral concerns" and client #2 was readmitted back to the behavior inpatient unit. No medication changes were made during her inpatient stay. On 1/22/15 client #2 returned to the group home from the inpatient unit. On 1/25/15 client #2 was taken by "ambulance due to behavioral concerns of seeming ok to throwing items and becoming combative, slurring speech, and throwing things in a matter of seconds." The IDT note indicated the ER could not identify a medical issue and client #2 was referred to the behavioral inpatient unit. The inpatient unit was unable to admit client #2 and client #2 was returned to the group home.</p> <p>On 1/23/15 at 10:00am, an interview with the RC was conducted. The RC stated client #2 had been self injurious, tore up her wheel chair, threw objects, pulled her hair, scratched herself, and dropped to the ground/floor which "might" account for</p>				

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W000157	<p>"some" of client #2's bruises. The RC indicated client #2 received the black eye at the hospital after a fall. When asked if there was any documentation available for review of client #2's unknown bruises, the RC stated "No." The RC indicated there was not a BDDS report or documentation available for review which recorded of the amount, type, and colors of the unknown bruises on client #2's body.</p> <p>On 1/26/15 at 1:30pm, the RC indicated she had obtained client #2's hospital summary which indicated client #2 had fallen out of her wheel chair during her stay and the result was a black eye. No further information was available for review. The RC indicated no BDDS report or documentation was available for review of the amount, type, and colors of client #2's unknown bruises to her body.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 4 of 7 clients (clients #2, #3, #4 and #7) and for 12 medication errors, the facility failed to complete effective corrective action to address a pattern of medication</p>	W000157	<p>W157</p> <p>If the alleged violation is verified,</p>	02/20/2015

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	<p>errors to ensure staff administered medications without error and as prescribed by the clients' physician.</p> <p>Findings include:</p> <p>On 1/22/15 at 1:45pm, and on 1/23/15 at 10:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 7/2014 through 1/22/15 were reviewed and indicated the following medication errors:</p> <p>1. For client #2: -An 8/29/14 BDDS report for an incident on 8/28/14 at 8:00am indicated the Residential Manager (RM) "was reviewing the MARS (Medication Administration Records) as she routinely does for the next month. While comparing the current months MARS (sic) to the MARS of the upcoming month she found a discrepancy with [client #2's] Trazodone (for sleep). The current MARS noted that [client #2] was taking 150mg (milligrams) a day and the new MAR reflected she was to be taking 50mg. Upon speaking to the nurse and the QDP (Qualified Intellectual Disabilities Professional) it was found that on 2/6/14 [client #2] psychiatrist reduced her Trazodone from 100mg to 50mg. When [client #2] went to see her neurologist in 5/2014 he increased the</p>		<p>appropriate corrective action must be taken.</p> <p>Cardinal Services, Inc. has in effect procedures to assure safe and responsible administration of prescription and non-prescription medication, as well as tracking process to provide training and discipline for non-compliance.</p> <p>Training on medication changes to the MAR and Medication Administration was provided to the Residential Manager and all Direct Support Staff working in the home on 2/13/15 (see attachment I, J). The facility has implemented medication administration reminders on the iPads within the home. For each Medication Administration time the alarm on the iPad will sound alerting staff that it is time to administer medications. The Residential Manager and all Direct Support Staff working in the home were trained on 2/13/15 (see attachment K). All Direct Support Staff will receive training by 2/27/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the implementation of all individualized</p>				

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	<p>Trazodone back to 100mg. When she was released from an inpatient stay on 5/16/14 her psychiatrist wrote the Trazodone script for 100mg. [Client #2] went to her psychiatrist for a routine appointment on 8/7/14. Her psychiatrist made note that he wanted [client #2] to continue her current medications and he wrote renewal scripts. When he wrote the script for Trazodone he wrote it for 50mg and did not state that it was a decrease. The scripts were taken to the pharmacy to be filled and they were sent to the home by the pharmacy. When staff wrote the orders on the MAR they did not discontinue the 100mg of Trazodone as they did not have an order to do so, they added the 50mg onto the MAR. [Client #2] has received 150mg of Trazodone since 8/8/14 instead of 50mg." The 8/28/14 investigation indicated the agency nurse reviewed client #2's record, physician's orders, and MARs. The investigation indicated the nurse "returned" and corrected client #2's current MAR to have 50mg of Trazodone. The report indicated the corrective action was that staff was counseled on medication administration and was observed by the agency passing medications.</p> <p>On 1/23/15 at 9:35am, client #2's record was reviewed. Client #2's 11/2014</p>		<p>plans and agency Policies through weekly, monthly and quarterly observations.</p> <p><b>Residential Manager, Residential Nurse and Residential Coordinator responsible</b></p>				

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	<p>"Physician's Order" indicated "Trazodone 50mg" for depression for sleep.</p> <p>2. For client #3: -An 10/16/14 BDDS report for an incident on 10/16/14 at 6:00am indicated Group Home Staff (GHS) #4 was "preparing medications for [client #3], [GHS #4] actually punched out [client #4's] medications and distributed them to [client #3]. [GHS #4] immediately called the residential manager and the nurse." Client #3's vital signs were monitored and her physician was notified. The report indicated corrective measures included: staff was counseled on medication administration and was observed by the agency for staff passing medications.</p> <p>-The 10/17/14 "Medication Error Form" indicated client #3 was administered client #4's medications of: "Provera 2.5mg (a female hormone replacement), Meloxicam 15mg (for pain), Omeprazole 40mg (for acid reflux), Oxybutynin Cl ER 10mg (for incontinence), Premarin 0.625mg (for symptoms of menopause), Therapeutic M Tablet (a vitamin), Keppra 750mg (for seizures), and Trazodone 100mg (anti anxiety)."</p> <p>On 1/26/15 at 10:50am, client #3's record was reviewed. Client #3's 11/2014</p>						

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	<p>"Physician's Order" did not indicate the use of "Provera 2.5mg (a female hormone replacement), Meloxicam 15mg (for pain), Omeprazole 40mg (for acid reflux), Oxybutynin Cl ER 10mg (for incontinence), Premarin 0.625mg (for symptoms of menopause), Therapeutic M Tablet (a vitamin), Keppra 750mg (for seizures), and Trazodone 100mg (anti anxiety)."</p> <p>3. For client #4: -A 1/19/15 BDDS report indicated an incident on 1/19/15 at 10:00pm of omitted "Nucynta 50mg (milligrams) at 10:00pm" for pain. The report indicated corrective measures included staff was counseled on medication administration and was observed passing medications.</p> <p>-A 1/13/15 BDDS report indicated an incident on 1/11/15 at 10:00pm of omitted "Nucynta 50mg" medication at 10:00pm. The report indicated corrective measures included staff was counseled on medication administration and was observed passing medications.</p> <p>-A 11/11/14 BDDS report indicated an incident on 11/10/14 at 10:00pm of omitted "Nucynta 50mg" medication at 10:00pm. The report indicated corrective measures included staff was counseled on medication administration and was</p>			

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	<p>observed passing medications.</p> <p>-A 9/5/14 BDDS report indicated an incident on 9/5/14 at 12:00pm indicated "on 9/5/14 at 12:00pm, [client #4] was given a 1mg Lorazepam (for anxiety) tablet instead of her 100mg Trazodone (anti anxiety)." The report indicated corrective measures included staff was counseled on medication administration and was observed passing medications.</p> <p>-An 8/7/14 BDDS report indicated an incident on 8/6/14 at 3:45pm indicated client #4 did not receive her 2:00pm dose of "Nucynta 50mg" pain medication. The report indicated corrective measures included staff was counseled on medication administration and was observed passing medications.</p> <p>-An 8/4/14 BDDS report indicated an incident on 8/3/14 at 10:00pm of omitted "Nucynta 50mg" medication at 10:00pm. The report indicated corrective measures included staff was counseled on medication administration and was observed passing medications.</p> <p>-A 7/14/14 BDDS report indicated for an incident on 7/12/14 at 2:00pm indicated client #4 was "given Tramadol (for pain) 50mg on 7/12/14 at 2pm and this PRN (as needed) had been discontinued from</p>			

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	<p>the doctor." The report indicated after this incident client #4's Tramadol medication was removed from the medication cabinet.</p> <p>On 1/26/15 at 12:30pm, client #4's record was reviewed. Client #4's 11/2014 "Physician's Order" indicated "Nucynta 50mg (milligrams) at 10:00pm" for pain.</p> <p>4. For client #7: -A 1/13/15 BDDS report indicated an incident on 1/11/15 at 8:00pm of omitted medication "Depakote 250mg (for seizures) at 8:00pm. The report indicated corrective measures staff was counseled on medication administration and was observed passing medications.</p> <p>On 1/26/15 at 11:00am, client #7's record was reviewed. Client #7's 11/2014 "Physician's Order" indicated "Depakote 250mg" for anxiety.</p> <p>On 1/28/15 at 9:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and Adult Services Director (ASD) was conducted. The QIDP and ASD both indicated staff should administer medications according to physician's orders. The QIDP and ASD both indicated staff did not follow the medication administration policy and procedure when medications were not</p>			

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W000227	<p>administered according to physician's orders for clients #2, #3, #4, and #7. The ASD indicated if the medication errors were current than it would be a pattern and the corrective measures were not effective. The ASD indicated if the medication errors were months ago than the corrective measures were effective because the error did not occur additional times.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #2), the facility failed to develop a program to address client #2's identified Self Injurious Behavior (SIB) needs.</p> <p>Findings include:</p> <p>On 1/22/15 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for client #2 and did not include any reports of bruises or bodily injuries.</p> <p>On 1/22/15 from 4:05pm until 6:15pm,</p>	W000227	<p><b>W227</b> The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. The facility has provided training to the QDP (see attachment H) to address program development to include client #2's identified Self Injurious Behavior needs. The QDP amended the Individual Support Plan and provided training to staff regarding these revisions on 2/17/15 (see attachment F). To ensure this deficiency does not occur in the future, the</p>	02/20/2015

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	<p>observation and interviews were completed at the group home with client #2. At 4:05pm, GHS (Group Home Staff) #1 indicated client #2 had returned home from the hospital around noon. At 4:05pm, client #2 was observed with a black right eye. Client #2's eye had black, green, brown, and yellow colors around, above, and below the eye. At 4:05pm, GHS #1 and the RM (Residential Manager) both stated client #2 returned from the hospital inpatient unit 1/22/15 at "around noon" and had the black eye. At 4:05pm, client #2 sat in a recliner in the living room at the group home, extended her right hand and the RM stated both client #2's wrist and forearm had "more than three or four" yellow, green, brown, black, and gray bruises. At 5:15pm, the RM stated she (the RM) was called by the inpatient unit "on Tuesday or Wednesday" and was told by staff at the inpatient unit that client #2 "had fallen out of her wheel chair. The [inpatient unit staff] took [client #2] to the hospital the next day after the goose egg above her right eye had moved down to blacken [client #2's] right eye." The RM stated client #2 had "other bruises on her body." The RM indicated client #2 had self injurious behaviors of rubbing her foot on top of the opposite lower leg which cause injuries before being admitted to the hospital and during this</p>		<p>Coordinator will monitor assessment and goal development through documentation review, internal audits and observation. Spot checks will be completed by the Coordinator monthly and the QDPs will be completing peer reviews quarterly. The QDP will ensure ongoing compliance through weekly, monthly and quarterly observations. <b>Coordinator and QDP responsible</b></p>				

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	<p>hospital stay emergency personnel had to restrain client #2 while being admitted to the hospital. The RM indicated no documentation was available for review of client #2's SIB behaviors. The RM spoke to client #2, client #2 shifted in her seat, and moved her bruised hand to rub her lower leg. Client #2 moved her pant leg which exposed additional bruises on client #2's lower leg which were green, yellow, brown, and black in color. The RM stated there "were more than four" additional bruises. The RM stated client #2 had "bruises all over her." The RM indicated she did not have knowledge regarding client #2's bruises. The RM indicated no documentation was available for review from the hospital or from the group home which recorded the multiple unknown bruises on client #2's body or their source.</p> <p>On 1/23/15 from 5:50am until 7:55am, observation and interviews were conducted at the group home with client #2. At 6:50am, the RM indicated client #2 had been suspended from riding the workshop bus because of her physically aggressive behaviors. The RM indicated client #2 was hitting other clients, hurting herself, and hitting staff during the transition time from the group home, onto the workshop bus, and after the bus arrived at the workshop. From 7:35am</p>			

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	<p>until 7:55am, client #2 was at the group home. The RM indicated client #2 had stayed home from workshop since she returned from the hospital on 1/22/15.</p> <p>On 1/23/15 at 7:55am, the RM indicated client #2's plans had no written guidelines for client #2's Self Injurious Behaviors.</p> <p>Client #2's record was reviewed on 1/23/15 at 9:35am. Client #2's 5/20/14 ISP (Individual Support Plan) and 5/20/14 SMP (Self Management Plan) did not indicate client #2 had identified SIB behaviors during transition periods from the group home, on the workshop bus, and once arriving at the workshop. Client #2's SMP listed targeted behaviors which included, but were not limited to: Physical Aggression, Verbal Aggression, Inappropriate Touch, Depression, and Irritability. Client #2's record indicated client #2 had multiple physically aggressive behaviors during 10/2014, 11/2014, and 12/2014 during transports on the workshop bus, refusing to exit the workshop bus, and after getting off the workshop bus. Client #2's record indicated client #2 had been suspended because of physically aggressive behaviors from riding the workshop bus and was returned home by car on 12/30/14. Client #2's record did not</p>			

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	<p>indicate client #2 had bruises on her body and did not indicate she had self injurious behaviors.</p> <p>On 1/27/15 at 3:00pm, the Residential Coordinator (RC) provided client #2's 1/26/2015 "IDT (Interdisciplinary Team) notes" which indicated the following: -"The IDT met to review recent behavioral issues and also to discuss the recent incident from this past weekend on 1/25/15...[Client #2] had an ER (Emergency Room) visit on 12/30/14, during that time she had bloodwork completed and a CAT scan and then was transferred to [inpatient behavioral unit] due to being very combative with all staff and emergency personnel." The report indicated all results were within normal limits. "While at the inpatient unit, the doctor started [client #2] on Depakote 250mg (milligrams). Her sodium dropped and [client #2] was transferred back to the hospital." The report indicated once client #2's blood levels returned to normal client #2 was transferred back to the inpatient behavioral unit. Client #2 was released to the group home 1/8/15. Client #2's medications were changed again and client #2 became "stable" with her behaviors. On 1/18/15 client #2 was "readmitted back to the ER due to behavioral concerns" and client #2 was</p>			

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	<p>readmitted back to the behavior inpatient unit. No medication changes were made during her inpatient stay. On 1/22/15 client #2 returned to the group home from the inpatient unit. On 1/25/15 client #2 was taken by "ambulance due to behavioral concerns of seeming ok to throwing items and becoming combative, slurring speech, and throwing things in a matter of seconds." The IDT note indicated the ER could not identify a medical issue and client #2 was referred to the behavioral inpatient unit. The inpatient unit was unable to admit client #2 and client #2 was returned to the group home. The IDT note did not include evidence and discussion regarding Self Injurious Behaviors.</p> <p>On 1/26/15 at 1:30pm, and on 1/27/15 at 11:00am, client #2's written guidelines for staff to implement during transitional periods and SIB were requested from the Residential Coordinator (RC). No guidelines were available for review for clients #2.</p> <p>On 1/23/15 at 10:00am, an interview with the RC was conducted. The RC stated client #2 had been self injurious, tore up her wheel chair, threw objects, pulled her hair, scratched herself, and dropped to the ground/floor which "might" account for "some" of client #2's bruises. The RC</p>						

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W000240	<p>indicated client #2 received the black eye at the hospital after a fall. When asked if there was any documentation available for review of client #2's bruises, the RC stated "No." The RC indicated there was not a BDDS report or documentation available for review which recorded the amount, type, and colors of the unknown bruises on client #2's body. The RC indicated no guidelines were available for review for client #2's Self Injurious Behaviors.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) who had physically aggressive behaviors and behavioral issues during transition for the bus transport, workshop, and group home, the facility failed to develop guidelines in the clients' ISPs (Individual Support Plan) and/or BSPs (Behavior Support Plan) for client #1 and #2's transition from location to location.</p> <p>Findings include:</p>	W000240	<p><b>W240</b></p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>The facility has provided training to the QDP (see attachment H) to address program development to include specific guidelines for helping client #1 and client # 2 with</p>	02/20/2015

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	<p>On 1/22/15 from 4:05pm until 6:15pm, observation and interviews were completed at the group home with clients #1 and #2. At 4:05pm, GHS (Group Home Staff) #1 indicated clients #3, #4, #5, #6, and #7 had arrived home from the workshop on the workshop bus. At 4:05pm, GHS #1 indicated client #2 had returned home from the hospital around noon. From 4:05pm until 4:50pm, client #1 was not at the group home. At 4:25pm, GHS #1 stated client #1 was not home yet from day services and client #1 "had issues on the bus." At 4:25pm, the Residential Manager (RM) stated client #1 had physically aggressive behaviors on the bus and "had been suspended" from riding the bus "about two (2) months." At 4:50pm, client #1 arrived at the group home with a workshop staff person driving a personal car.</p> <p>On 1/23/15 from 5:50am until 7:55am, observation and interviews were conducted at the group home with clients #1 and #2. At 6:50am, the RM indicated clients #1 and #2 had been suspended from riding the workshop bus because of their physically aggressive behaviors. The RM indicated clients #1 and #2 were hitting other clients, hurting themselves, and hitting staff during the transition time from the group home, onto the workshop bus, and after the bus arrived at the</p>		<p>a smooth transition from the bus to Day Services and from Day Services to home.</p> <p>The QDP amended the Individual Support Plans and provided training to staff regarding these revisions on 2/17/15 (see Attachments F, G).</p> <p>To ensure this deficiency does not occur in the future, the Coordinator will monitor assessment and goal development through documentation review, internal audits and observation. Spot checks will be completed by the Coordinator monthly and the QDPs will be completing peer reviews quarterly. The QDP will ensure ongoing compliance through weekly, monthly and quarterly observations.</p> <p><b>Coordinator and QDP responsible</b></p>		

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	<p>workshop. At 7:20am, clients #3, #4, #5, #6, and #7 put on their coats, gathered their personal items and waited on the facility workshop bus to arrive. At 7:26am, the bus arrived and clients #3, #4, #5, #6, and #7 were assisted by the facility staff to leave the group home and load onto the bus. Client #1 stood in the living room window watching and kept verbally repeating "bus" and pointing to the bus. At 7:26am, the RM stated "I think she (client #1) misses riding the bus." The RM indicated clients #1 and #2 were both suspended because of behavioral issues while riding the workshop bus. At 7:35am, the bus began to pull away from the driveway of the group home and client #1's facial expression changed to a sad look as the bus drove away from the group home. From 7:35am until 7:55am, clients #1 and #2 were at the group home. Client #2 stayed home from workshop since she returned from the hospital on 1/22/15. At 7:55am, the RM stated client #1 "was waiting on her (the RM) for transportation" to the agency in a private car because client #1 could not ride the workshop bus.</p> <p>On 1/26/15 at 11:40am, client #1's record review was conducted. Client #1's 10/2/14 ISP (Individual Support Plan) and 10/2/14 SMP (Self Management</p>			

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	<p>Plan) did not indicate she had identified behaviors during transition periods from the group home, on the workshop bus, and once arriving at the workshop.</p> <p>Client #1's SMP listed targeted behaviors which included, but were not limited to: Physical Aggression, Self Abuse, Strong Opposition to Programming, Inappropriate Touching, Property Destruction, and Depression. Client #1's SMP indicated "...I respond best to a highly structured, low stimulus environment. This means that I am the happiest when I have a strictly followed set schedule and I know what is going to happen...I become upset when my schedule is interrupted or changed or my environment is too loud or chaotic. Staff should avoid chaotic, loud, or crowded places when taking me on CBI (Community Based Integration)...."</p> <p>Client #1's SMP indicated she "required" one on one staff supervision and staff were to position themselves between client #1 and other clients for safety.</p> <p>Client #1's 11/26/14 "IDT (Interdisciplinary Team) Notes" indicated "The IDT team met to discuss and review recent behavioral issues and recent incident reports. Staff report [client #1] has had more behavioral issues over the last month or so during transition periods at work and some at home. [Client #1] has had issues while on the bus and has</p>			

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	<p>caused concern for the safety of others while on the bus. [Client #1] has recently been suspended from the bus until further notice." The 11/26/14 IDT note indicated client #1 had experienced changes in her psychiatric medications in 11/2014 and 10/2014 and changes in staff members at the group home. The 11/26/14 IDT note did not indicate when client #1's suspended bus status would be re-evaluated and no guidelines were documented to address client #1's transitional behavior issues.</p> <p>Client #2's record was reviewed on 1/23/15 at 9:35am. Client #2's 5/20/14 ISP (Individual Support Plan) and 5/20/14 SMP (Self Management Plan) did not indicate client #2 had identified behaviors during transition periods from the group home, on the workshop bus, and once arriving at the workshop. Client #2's SMP listed targeted behaviors which included, but were not limited to: Physical Aggression, Verbal Aggression, Inappropriate Touch, Depression, and Irritability. Client #2's record indicated client #2 had multiple physically aggressive behavior incidents during 10/2014, 11/2014, and 12/2014 during transports on the workshop bus, refusing to exit the workshop bus, and after getting off the workshop bus. Client #2's record indicated client #2's first</p>			

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	<p>documented suspension from riding the workshop bus because of physically aggressive behaviors occurred on 12/30/14 and she was returned to the group home by car.</p> <p>On 1/27/15 at 3:00pm, the Residential Coordinator (RC) provided client #2's 1/26/2015 "IDT notes" which indicated the following: -"The IDT met to review recent behavioral issues and also to discuss the recent incident from this past weekend on 1/25/15...[Client #2] had an ER (Emergency Room) visit on 12/30/14, during that time she had bloodwork completed and a CAT scan and then was transferred to [inpatient behavioral unit] due to being very combative with all staff and emergency personnel." The report indicated all results were within normal limits. "While at the inpatient unit, the doctor started [client #2] on Depakote 250mg (milligrams). Her sodium dropped and [client #2] was transferred back to the hospital." The report indicated once client #2's blood levels returned to normal client #2 was transferred back to the inpatient behavioral unit. Client #2 was released to the group home 1/8/15. Client #2's medications were changed again and client #2 became "stable" with her behaviors. On 1/18/15 client #2 was</p>			

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	<p>"readmitted back to the ER due to behavioral concerns" and client #2 was readmitted back to the behavior inpatient unit. No medication changes were made during her inpatient stay. On 1/22/15 client #2 returned to the group home from the inpatient unit. On 1/25/15 client #2 was taken by "ambulance due to behavioral concerns of seeming ok to throwing items and becoming combative, slurring speech, and throwing things in a matter of seconds." The IDT note indicated the ER could not identify a medical issue and client #2 was referred to the behavioral inpatient unit. The inpatient unit was unable to admit client #2 and client #2 was returned to the group home.</p> <p>On 1/26/15 at 1:30pm, and on 1/27/15 at 11:00am, client #1 and #2's written guidelines for staff to implement during transitional periods were requested from the Residential Coordinator (RC). No guidelines were available for review for clients #1 and #2.</p> <p>On 1/27/15 at 1:11pm, an interview with the Support Services Coordinator (SSC) was conducted. The SSC indicated there were no written guidelines for staff to follow in the clients' ISPs or BSPs to address client #1 and #2's transition periods from the group home, on the</p>				

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W000331	<p>workshop bus, or at the workshop. The SSC indicated she supervised the QIDP (Qualified Intellectual Disabilities Professionals) at the agency. The SSC indicated client #1 was suspended from riding the bus and client #2 was not suspended from riding the bus.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility's nursing services failed to develop protocols specific to client #4 to monitor and to manage her pain.</p> <p>Findings include:</p> <p>On 1/23/15 at 6:15am, client #4 was asked to come to the medication closet with Group Home Staff (GHS) #2. GHS #2 selected client #4's "ARX Pain Cream, 2 pumps, 3 times daily to R (right) knee" for pain, "Nucynta 50mg (milligrams) every 8 hours to relieve pain," and "Meloxicam, 15mg once a day" for arthritis pain. GHS #2 administered the medications to client #4. At 6:15am, GHS #2 indicated client #4 had arthritis</p>	W000331	<p><b>W331</b></p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>The Residential Nurses received training regarding the development of client specific care plans on 2/17/15 (see attachment L). Client #4 Care Plan was amended to reflect specific individualized guidelines for assessing and treating this individual on 2/16/15 (see attachment M). Staff were trained on the updated plan on 2/17/15. (See attachment M.)</p>	02/20/2015

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	<p>pain and client #4 was non verbal. GHS #2 stated client #4 "would show facial expressions" when client #4 was in pain. GHS #2 indicated client #4's group home record did not have written guidelines or protocols to monitor client #4's pain. When asked if the medications were effective to monitor and manage client #4's pain, GHS #2 indicated she thought the medications were effective. GHS #2 reviewed client #4's medical section for information guidelines related to client #4's pain medications and no protocols were available.</p> <p>Client #4's record was reviewed on 1/26/15 at 12:30pm. Client #4's 11/14/14, 8/6/14, 4/8/14, and 2/17/14 nursing reviews did not address client #4's pain and use of pain medication. Client #4's diagnoses were updated by her physician on 6/2014 to include Arthritis. Client #4's 11/4/14 "Physician's Order" indicated ARX Pain Cream, 2 pumps, 3 times daily to R (right) knee" for pain, "Nucynta 50mg (milligrams) 1 tablet every 8 hours" to relieve pain, and "Meloxicam 15mg, 1 tablet once a day" for arthritis pain. Client #4's 1/19/15 "Nurses Note" indicated "An appointment was completed today with [Doctor Name] for follow up on knee pain. New orders to change Nucynta to ER and titrate to</p>		<p>To ensure systemic compliance across the agency, all Residential Nurses will receive training by February 27, 2015.</p> <p>To ensure this deficiency does not occur in the future, the Coordinator will monitor care plans for thoroughness in amendments through documentation review and internal audits. Spot checks will be completed by the Coordinator monthly and each time a new care plan is implemented it will be reviewed for thoroughness and accuracy. The Residential Nurse will ensure ongoing compliance through weekly, monthly and quarterly observations.</p> <p><b>Support Services Coordinator and Residential Nurse responsible</b></p>				

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W000368	<p>150mg...[Signed by the nurse]." No guidelines or protocols for client #4's pain were available for review.</p> <p>On 1/27/15 at 3:00pm, the Residential Coordinator (RC) provided a 6/26/14 "Care Plan" for client #4's "Pain related to Arthritis." The Care Plan indicated general information regarding arthritis, to manage pain, stiffness, and swelling, to improve mobility, and a list of general care instructions including, but not limited to administering medications, monitoring weight, and monitoring diet. The plan did not provide specific guidelines for client #4's pain, the location of client #4's pain, how client #4 communicates her pain/discomfort, medications administered for pain, and what works to assist client #4 with her pain.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 4 of 7 clients (clients #2, #3, #4 and #7), the facility failed to administer medications without error and as prescribed by the clients' physician.</p>	W000368	<p><b>W368</b> The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Cardinal Services, Inc. has in effect procedures to assure safe and responsible</p>	03/07/2015

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	<p>Findings include:</p> <p>On 1/22/15 at 1:45pm, and on 1/23/15 at 10:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 7/2014 through 1/22/15 were reviewed and indicated the following medication errors:</p> <p>1. For client #2: -An 8/29/14 BDDS report for an incident on 8/28/14 at 8:00am indicated the Residential Manager (RM) "was reviewing the MARS (Medication Administration Records) as she routinely does for the next month. While comparing the current months MARS (sic) to the MARS of the upcoming month she found a discrepancy with [client #2's] Trazodone (for sleep). The current MARS noted that [client #2] was taking 150mg (milligrams) a day and the new MAR reflected she was to be taking 50mg. Upon speaking to the nurse and the QDP (Qualified Intellectual Disabilities Professional) it was found that on 2/6/14 [client #2] psychiatrist reduced her Trazodone from 100mg to 50mg. When [client #2] went to see her neurologist in 5/2014 he increased the Trazodone back to 100mg. When she was released from an inpatient stay on 5/16/14 her psychiatrist wrote the</p>		<p>administration of prescription and non-prescription medication, as well as tracking process to provide training and discipline for non-compliance. The Residential Manager and all Direct Support Staff working in the home received training on Medication Administration and Recording a Medication Change on the MAR on 2/13/15 (see attachments J, I). The facility has implemented medication administration reminders on the iPads within the home. For each Medication Administration time the alarm on the iPad will sound alerting staff that it is time to administer medications. The Residential Manager and all Direct Support Staff working in the home were trained on 2/13/15 (see attachment K). All Direct Support Staff within the company received training by 2/27/15. The Medication Administration time for client #4 changed from 10:00 pm to 6:00 am and 6:00 pm when the PCP changed the Nucynta 50 mg to Nucynta ER 100mg on 1/19/15 (see attachment N). Since the order for the Nucynta changed and is now being given at a more routine time there have not been any further omissions of this medication. The staff responsible for the majority of the errors that occurred was not permitted to administer medications on her own until she repeated Med Core A on 1/27/15. Since completing this retraining</p>				

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	<p>Trazodone script for 100mg. [Client #2] went to her psychiatrist for a routine appointment on 8/7/14. Her psychiatrist made note that he wanted [client #2] to continue her current medications and he wrote renewal scripts. When he wrote the script for Trazodone he wrote it for 50mg and did not state that it was a decrease. The scripts were taken to the pharmacy to be filled and they were sent to the home by the pharmacy. When staff wrote the orders on the MAR they did not discontinue the 100mg of Trazodone as they did not have an order to do so, they added the 50mg onto the MAR. [Client #2] has received 150mg of Trazodone since 8/8/14 instead of 50mg." The 8/28/14 investigation indicated the agency nurse reviewed client #2's record, physician's orders, and MARs. The investigation indicated the nurse "returned" and corrected client #2's current MAR to have 50mg of Trazodone.</p> <p>On 1/23/15 at 9:35am, client #2's record was reviewed. Client #2's 11/2014 "Physician's Order" indicated "Trazodone 50mg" for depression for sleep.</p> <p>2. For client #3: -An 10/16/14 BDDS report for an incident on 10/16/14 at 6:00am indicated Group Home Staff (GHS) #4 was</p>		<p>and showing competency, this staff has not committed any medications errors. All Direct Support Staff working in the home will receive training on the Six Rights of Medication Administration by 3/7/15 (see attachment R).To ensure ongoing compliance with error free medication administration, the Residential Manager, Nurse, and Coordinator will monitor medication administration through weekly, monthly, and quarterly observations. The Quality Assessment Analysis Team will monitor monthly for trends. Quality Assessment Analysis Team includes Coordinators, Directors and Nurses. All orders will be sent to the Residential Nurse immediately following a medical appointment so the Nurse is aware of any changes needing made to a medication regimen for an individual. The staff receiving the new orders will make the change on the MAR and have a peer review the changes for accuracy. Once the MARS have been reviewed by a peer the Residential Nurse will be sent and notified of these changes immediately so she can review changes for accuracy and approve the changes.<b>Residential Manager, Nurse, Coordinator and Director responsible</b></p>				

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	<p>"preparing medications for [client #3], [GHS #4] actually punched out [client #4's] medications and distributed them to [client #3]. [GHS #4] immediately called the residential manager and the nurse." Client #3's vital signs were monitored and her physician was notified.</p> <p>-The 10/17/14 "Medication Error Form" indicated client #3 was administered client #4's medications of: "Provera 2.5mg (a female hormone replacement), Meloxicam 15mg (for pain), Omeprazole 40mg (for acid reflux), Oxybutynin Cl ER 10mg (for incontinence), Premarin 0.625mg (for symptoms of menopause), Therapeutic M Tablet (a vitamin), Keppra 750mg (for seizures), and Trazodone 100mg (anti anxiety)."</p> <p>On 1/26/15 at 10:50am, client #3's record was reviewed. Client #3's 11/2014 "Physician's Order" did not indicate the use of "Provera 2.5mg (a female hormone replacement), Meloxicam 15mg (for pain), Omeprazole 40mg (for acid reflux), Oxybutynin Cl ER 10mg (for incontinence), Premarin 0.625mg (for symptoms of menopause), Therapeutic M Tablet (a vitamin), Keppra 750mg (for seizures), and Trazodone 100mg (anti anxiety)."</p> <p>3. For client #4:</p>			

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	<p>-A 1/19/15 BDDS report indicated for an incident on 1/19/15 at 10:00pm of omitted "Nucynta 50mg (milligrams) at 10:00pm" for pain.</p> <p>-A 1/13/15 BDDS report indicated for an incident on 1/11/15 at 10:00pm of omitted "Nucynta 50mg" medication at 10:00pm.</p> <p>-A 11/11/14 BDDS report indicated for an incident on 11/10/14 at 10:00pm of omitted "Nucynta 50mg" medication at 10:00pm.</p> <p>-A 9/5/14 BDDS report indicated for an incident on 9/5/14 at 12:00pm indicated "on 9/5/14 at 12:00pm, [client #4] was given a 1mg Lorazepam (for anxiety) tablet instead of her 100mg Trazodone (anti anxiety)."</p> <p>-An 8/7/14 BDDS report indicated for an incident on 8/6/14 at 3:45pm indicated on client #4 did not receive her 2:00pm does of "Nucynta 50mg" for pain medication.</p> <p>-An 8/4/14 BDDS report indicated for an incident on 8/3/14 at 10:00pm of omitted "Nucynta 50mg" medication at 10:00pm.</p> <p>-A 7/14/14 BDDS report indicated for an incident on 7/12/14 at 2:00pm indicated client #4 was "given Tramadol (for pain)</p>			

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	<p>50mg on 7/12/14 at 2pm and this PRN (as needed) had been discontinued from the doctor." The report indicated after this incident client #4's Tramadol medication was removed from the medication cabinet.</p> <p>On 1/26/15 at 12:30pm, client #4's record was reviewed. Client #4's 11/2014 "Physician's Order" indicated "Nucynta 50mg (milligrams) at 10:00pm" for pain.</p> <p>4. For client #7: -A 1/13/15 BDDS report indicated for an incident on 1/11/15 at 8:00pm of omitted medication "Depakote 250mg (for seizures) at 8:00pm.</p> <p>On 1/26/15 at 11:00am, client #7's record was reviewed. Client #7's 11/2014 "Physician's Order" indicated "Depakote 250mg" for anxiety.</p> <p>On 1/28/15 at 9:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and Adult Services Director (ASD) was conducted. The QIDP and ASD both indicated staff should administer medications according to physician's orders. The QIDP and ASD both indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's</p>						

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W000436	<p>orders for clients #2, #3, #4, and #7.</p> <p>On 1/23/15 at 11:00am, a record review of the facility's 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #4) with adaptive equipment, the facility failed to teach and encourage clients #4 to wear her prescribed eye glasses.</p> <p>Findings include:</p> <p>On 1/22/15 from 4:05pm until 6:15pm, and on 1/23/15 from 5:50am until 7:55am, observations were conducted and client #4 did not wear her prescribed eye glasses. During both observation</p>	W000436	<p><b>W436</b></p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>All Direct Support Staff working</p>	02/20/2015

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	<p>periods client #4 completed dining, walked throughout the group home, completed medication administration, and watched television. Client #4 was not encouraged to wear her prescribed eye glasses.</p> <p>On 1/23/15 from 8:15am until 9:20am, client #4 was observed at the day services and wore her prescribed eye glasses. At 8:55am, client #4 sat at a computer with WKS (Workshop Staff) #1 and wore her prescribed eye glasses. At 8:55am, WKS #1 indicated client #4 wore her prescribed eye glasses daily and the glasses were kept inside a case located inside client #4's lunch box. WKS #1 indicated the eye glasses were transported to/from workshop daily with client #4 to the group home.</p> <p>Client #4's record was reviewed on 1/26/15 at 12:30pm. Client #4's 9/16/14 visual examination indicated client #4 wore prescribed eye glasses to see. Client #4's 9/16/14 visual examination had an added unsigned handwritten note different from the writing of the physician who completed the examination which indicated client #4 "makes own choice usually does not put on until arrives at day services. Sometimes takes off as soon as she gets home. Other times keeps on until</p>		<p>within the home received training on adaptive equipment as assessed and outlined in individual program plans upon new hire. The Residential Manager and the Direct Support staff in the Group Home received training to implement ongoing training as needed for persons served according to individualized plans; especially eye glasses according to prescribed use on 2/17/15 (see attachment O). An informal goal was implemented for client # 4 in regards to eye glass use on 2/18/15 (see attachment Q).</p> <p>To ensure systemic compliance across the agency, all Residential Managers and Direct Support Staff will receive training by February 27, 2015.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the implementation of all individualized plans and agency Policies through weekly, monthly and quarterly observations. The Support Services Coordinator will monitor support plans to ensure all necessary updates are completed promptly.</p> <p><b>Residential Manager, QDP, Day Services Coordinator and</b></p>				

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	<p>bedtime." Client #4's 8/18/14 ISP (Individual Support Plan) did not indicate an objective to teach and wear her prescribed eye glasses.</p> <p>On 1/23/15 at 10:40am, an interview was conducted with the Agency Nurse. The Agency Nurse indicated client #4 wore prescribed eye glasses.</p> <p>9-3-7(a)</p>		<b>Residential Coordinator responsible</b>				