

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G382	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/21/2012
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 213 N PARKER STREET WARSAW, IN 46580
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W0000	<p>This visit was for a predetermined full annual recertification and state licensure survey.</p> <p>Dates of Survey: September 17, 18, 19, 20, and 21, 2012</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>Facility number: 000896 Provider number: 15G382 AIM number: 100235140</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 9/24/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and four additional clients (clients #5, #6, #7, and #8), the facility failed to allow and encourage independent access to the double latched gated entry to the group home.</p> <p>Findings include:</p> <p>On 9/17/12 from 3:45pm until 6:40pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home and were not offered the opportunity or encouraged by GHT (Group Home Trainer) #1, #2, #3, #4, and the RM (Residential Manager) to open the double latched gated entry surrounding the exterior of the group home. At 3:45pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 arrived home from the workshop on the bus and exited the bus with GHT #1, GHT #2, GHT #3, and GHT #4. Clients #1, #2, #3, #4, #5, #6, #7, and #8 went to and stood waiting at the five foot tall double latched access gate for the group home. No clients were taught or encouraged to open the gate. At 3:55pm, GHT #1 stated client #5 "could possibly open" the double latched gated entry. GHT #1 stated clients #1, #2, #3, #4, #6, #7, and #8 "could not open" the double latched gate. GHT #1</p>	W0125	<p>W125</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Clients #1, #2, #3, #4, #5, #6, #7 and #8 were assessed regarding their ability to access the latched gate (measuring 50 inches tall) around their home. (See attachment A) Based on identified needs, an individualized training plan was developed for each client. (See attachment B) Staff will be trained on these plans by October 5, 2012. (See attachment C)</p> <p>To ensure ongoing compliance in provision of client rights, Coordinator, Manager and QMRP will monitor for training on accessing the gate through daily, weekly and monthly observations as well as</p>	10/21/2012			

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	<p>indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 were not given the opportunity to open the group home exterior access gate. At 5:50pm, GHT #1 indicated the double latched gated entry was in place for client safety from the busy street. GHT #1 indicated the double latched gate hardware was "only accessible from one side (of the gate)" which opened from the street side of the gate. At 6:30pm, the RM stated "I think [clients #4 and #5] could open the gate" to access the group home. The RM indicated clients #1, #2, #3, #6, #7, and #8 could not open the access gate independently. The RM indicated no client had a goal to open the gated entry to their group home.</p> <p>On 9/18/12 at 9:55am, client #1's record was reviewed. No documentation was available for review that client #1 had been assessed for the restriction regarding the double latched access gate to the group home.</p> <p>On 9/18/12 at 9:20am, client #2's record was reviewed. No documentation was available for review that client #2 had been assessed for the restriction regarding the double latched access gate to the group home.</p> <p>On 9/18/12 at 10:15am, client #3's record was reviewed. No documentation was available for review that client #3 had been assessed for the restriction regarding the double latched access gate to the group home.</p> <p>On 9/18/12 at 10:50am, client #4's record was reviewed. No documentation was available for</p>		<p>monthly documentation review.</p> <p>Coordinator, Manager and QMRP Responsible.</p>				

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	<p>review that client #4 had been assessed for the restriction regarding the double latched access gate to the group home.</p> <p>On 9/18/12 at 11:10am, an interview with the QMRP (Qualified Mental Retardation Professional) #1 and QMRP #2 was completed. QMRP #1 and QMRP #2 both indicated clients moved into this home in the spring of 2012 from other group homes within the agency. QMRP #1 and QMRP #2 both indicated no assessments for the restriction related to the double latched access gates were available for review for clients #1, #2, #3, #4, #5, #6, #7, and #8. Both QMRP #1 and QMRP #2 indicated the access gates opened from the street side of the gate and no latch for release was available from the yard side of the gate.</p> <p>On 9/18/12 at 11:10am, an interview with the Residential Coordinator (RC) was completed. The RC indicated the gate was a double latch mechanism and accessible from the street side of the gate. The RC indicated the double latch gate was secure, not accessible for clients, and a restriction. The RC indicated no assessments were available for review for the restriction of double latched gates for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>9-3-2(a)</p>				

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W0137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, record review, and interview, for 1 of 2 clients (client #6) who had locked personal belongings living in the group home, the facility failed to allow and encourage client #6's unimpeded access to his personal belongings.</p> <p>Findings include:</p> <p>On 9/17/12 from 3:45pm until 6:40pm, and on 9/18/12 from 5:50am until 7:45am, client #6's personal belongings were locked inside his closet. On 9/17/12 at 4pm, GHT (Group Home Trainer) #1 stated client #3 and #6's shared bedroom closets were locked "because [client #3] will shred his clothing and [client #6's] clothing." GHT #1 showed a key, stated "we keep it with us," and indicated client #6 did not have a key. GHT #1 indicated client #6 did not have unimpeded access to his personal belongings inside his locked closet.</p> <p>On 9/18/12 at 11:10am, an interview was conducted with the QMRP #1 (Qualified</p>	W0137	<p>W137 The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Client #6 was assessed as to his ability to access his personal belongings using a key. (See Attachment D) Based on assessment, individualized training protocol was put in place for client #6. (See Attachment E) Staff will receive specific training regarding this protocol by October 7, 2012. (See Attachment F) To ensure ongoing compliance with the right to retain and use personal possessions, Coordinator, Manager and QMRP will monitor for training on the use of a key through daily, weekly and monthly observations as well as monthly documentation review. Coordinator, Manager and QMRP Responsible.</p>	10/21/2012			

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	<p>Mental Retardation Professional) and QMRP #2. Both QMRP #1 and QMRP #2 indicated client #6's personal clothing and belongings were locked because of client #3's behavior of tearing clothing. QMRP #1 and QMRP #2 indicated client #6 did not have an identified need for locked personal items. QMRP #1 and QMRP #2 indicated client #6 did not have a goal/objective to teach him to access his locked personal belongings inside his closet.</p> <p>On 9/18/12 at 1pm, client #6's record was reviewed. Client #6's 8/16/12 ISP (Individual Support Plan) did not include a goal/objective to teach client #6 to access his locked personal belongings and closet.</p> <p>9-3-2(a)</p>			

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W0149	<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.</p> <p>Based on record review and interview, for 3 of 4 reviewed injuries of unknown origin for 3 of 8 clients living in the group home (clients #1, #5, and #6), the facility failed to immediately report to the Administrator in accordance to state law and to thoroughly investigate injuries of unknown origin.</p> <p>Findings include:</p> <p>On 9/17/12 at 1pm, the facility's internal "Accident/Incident Reports" were reviewed and indicated the following:</p> <p>For client #1: An "Accident/Incident Report" on 4/19/12 at "unknown" time, indicated client #1 got off the bus for workshop "coming into the classroom staff noticed a reddened area on top of [client #1's] left hand especially over his knuckles." No notification of the administrator and no investigation were available for review.</p> <p>For client #5: An "Accident/Incident Report" on 5/15/12 at 11:45am, indicated "staff noted blood on [client #5's] right ring and pinky fingernails. Staff assisted</p>	W0149	<p>W 149</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Cardinal Services strives to ensure that the people we support are free from abuse and neglect and work towards complying with all ISDH reporting guidelines. Residential Managers received training by September 21, 2012 stating that all injuries of unknown origin must be reported immediately upon discovery to the on call supervisor and as a BDDS Incident Report within 24 hours of discovery. (See Attachment G) On September 21, 2012 QDPs received training regarding the monitoring process for reviewing internal Accident/Injury reports to ensure that all injuries of unknown origin are reported. (See Attachment H) To ensure over-all agency compliance all staff will receive training by October 7, 2012 stating that all injuries of unknown origin must be reported immediately upon discovery to the on call supervisor and as a BDDS Incident Report within 24 hours of discovery.</p>	10/07/2012			

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	<p>[client #5] in cleaning himself and investigated the source of the blood. Staff found a small pea size scrape on the left right finger toward the pinky." The report indicated "due to the blood" on client #5 other hand staff concluded that his injury was self inflicted." No notification of the administrator and no investigation were available for review.</p> <p>For client #6: An "Accident/Incident Report" on an "undated" and "unknown" time, indicated client #6 had a "dime size purple/black bruise on left upper bicep." The report indicated "while assisting [client #6] into shower staff discovered dime size purple/black bruise" and signed by Group Home Trainer on 1/5/12. No notification of the administrator and no investigation were available for review.</p> <p>On 9/18/12 at 11:10am, an interview was conducted with the RC (Residential Coordinator). The RC indicated the facility followed the BDDS guidelines to immediately report to the Administrator injuries of unknown origin. The RC indicated staff were trained annually for reporting allegations, incidents, and injuries of unknown origin immediately to BDDS and to the administrator.</p> <p>On 9/18/12 at 2pm, the RC indicated no investigations were available for review</p>		<p>(See Attachment I) Additionally Cardinal Services Abuse/Neglect/Exploitation Policy was revised to clearly state that all injuries of unknown origin must be reported. (See Attachment J) Agency staff will receive training on the policy revision by October 7, 2012. (See Attachment K)</p> <p>To ensure compliance all internal Accident/Injury reports will be monitored by document review by the QDP, Residential Manager and Residential Coordinator.</p> <p>QDP, Residential Manager and Residential Coordinator Responsible</p>		

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	<p>of client #1, #5, and #6's injuries of unknown origin. The RC stated "all" injuries of unknown origin should be reported to the administrator and investigated.</p> <p>On 9/17/12 at 1:30pm, 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...1.13 Injuries of unknown origin where the injury could be indicative of abuse, neglect, or exploitation or requires medical evaluation or treatment...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>			

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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 record review and interview, for 3 of 4 injuries of unknown origin reviewed for 3 of 8 clients living in the group home (clients #1, #5, and #6), the facility failed to immediately report to the Administrator in accordance to state law for injuries of unknown origin.</p> <p>Findings include:</p> <p>On 9/17/12 at 1pm, the facility's internal "Accident/Incident Reports" were reviewed and indicated the following:</p> <p>For client #1: An "Accident/Incident Report" on 4/19/12 at "unknown" time, indicated client #1 got off the bus for workshop "coming into the classroom staff noticed a reddened area on top of [client #1's] left hand especially over his knuckles." No notification of the administrator was available for review.</p> <p>For client #5: An "Accident/Incident Report" on 5/15/12 at 11:45am, indicated "staff noted blood on [client #5's] right</p>	W0153	<p>W 153</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>Cardinal Services is committed to following all ISDH guidelines. To ensure that the administrator or other officials are notified of injuries of unknown origin immediately the Cardinal Services Inc. Abuse/Neglect/Exploitation Policy was revised to clearly state that all injuries of unknown origin are reported immediately to the on call supervisor. (See Attachment J) Agency staff will receive training on the policy revision by October 7, 2012. (See Attachment K) Residential Managers received training by September 21, 2012 stating that all injuries of unknown origin must be reported immediately upon discovery to the on call supervisor. (See Attachment G) To</p>	10/07/2012

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	<p>ring and pinky fingernails. Staff assisted [client #5] in cleaning himself and investigated the source of the blood. Staff found a small pea size scrape on the left right finger toward the pinky." The report indicated "due to the blood" on client #5 other hand staff concluded that his injury was self inflicted." No notification of the administrator was available for review.</p> <p>For client #6: An "Accident/Incident Report" on an "undated" and "unknown" time, indicated client #6 had a "dime size purple/black bruise on left upper bicep." The report indicated "while assisting [client #6] into shower staff discovered dime size purple/black bruise" and signed by Group Home Trainer on 1/5/12. No notification of the administrator was available for review.</p> <p>On 9/18/12 at 11:10am, an interview was conducted with the RC (Residential Coordinator). The RC indicated the facility followed the BDDS guidelines to immediately report to the Administrator injuries of unknown origin. The RC indicated staff were trained annually for reporting allegations, incidents, and injuries of unknown origin immediately to BDDS and to the administrator.</p> <p>9-3-2(a)</p>		<p>ensure over-all agency compliance all staff will receive training by October 7, 2012 stating that all injuries of unknown origin must be reported immediately upon discovery to the on call supervisor and as a BDDS Incident Report within 24 hours of discovery. (See Attachment I)</p> <p>To ensure compliance all internal Accident/Injury reports will be monitored by document review by the QDP, Residential Manager and Residential Coordinator.</p> <p>Residential Manager and Residential Coordinator Responsible</p>		

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, for 3 of 4 injuries of unknown origin reviewed for 3 of 8 clients living in the group home (clients #1, #5, and #6), the facility failed to thoroughly investigate injuries of unknown origin.</p> <p>Findings include:</p> <p>On 9/17/12 at 1pm, the facility's internal "Accident/Incident Reports" were reviewed and indicated the following:</p> <p>For client #1: An "Accident/Incident Report" on 4/19/12 at "unknown" time, indicated client #1 got off the bus for workshop "coming into the classroom staff noticed a reddened area on top of [client #1's] left hand especially over his knuckles." No investigation was available for review.</p> <p>For client #5: An "Accident/Incident Report" on 5/15/12 at 11:45am, indicated "staff noted blood on [client #5's] right ring and pinky fingernails. Staff assisted [client #5] in cleaning himself and investigated the source of the blood. Staff found a small pea size scrape on the left</p>	W0154	<p>W 154</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Residential Managers received training on investigation procedures on September 18, 2012 stating that, "Supervisors are to investigate any reportable incidents within 24 hours." (See Attachment L) In order to ensure consistency with investigation procedures a standardized "Investigation-Person Served" form was created on September 28, 2012. Residential Managers will receive training on and begin using this format by October 5, 2012. (See Attachment M)</p> <p>To ensure that thorough and timely investigations are completed Coordinator will monitor, receive and review all investigations on an ongoing, as needed basis.</p> <p>Department Coordinators Responsible</p>	10/05/2012			

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	<p>right finger toward the pinky." The report indicated "due to the blood" on client #5 other hand staff concluded that his injury was self inflicted." No investigation was available for review.</p> <p>For client #6: An "Accident/Incident Report" on an "undated" and "unknown" time, indicated client #6 had a "dime size purple/black bruise on left upper bicep." The report indicated "while assisting [client #6] into shower staff discovered dime size purple/black bruise" and signed by Group Home Trainer on 1/5/12. No investigation was available for review.</p> <p>On 9/18/12 at 2pm, the RC indicated no investigations were available for review of client #1, #5, and #6's injuries of unknown origin. The RC stated "all" injuries of unknown origin should be thoroughly investigated.</p> <p>9-3-2(a)</p>			

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and four additional clients (clients #5, #6, #7, and #8), the facility HRC (Human Rights Committee) failed to review the facility practice related to restrictive access for the double latched gated entry to group home and to adequately evaluate the need for the restriction.</p> <p>Findings include:</p> <p>On 9/17/12 from 3:45pm until 6:40pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home and were not offered the opportunity or encouraged by GHT (Group Home Trainer) #1, #2, #3, #4, and the RM (Residential Manager) to open the double latched five foot (5') tall gated entry surrounding the exterior grounds of the group home. At 3:45pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 arrived home from the workshop on the</p>	W0264	The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. The Human Rights Committee will review and make recommendations to the facility practice related to the latched gate around the home on 10-10-12. Please refer to W125 regarding assessment of individuals and training protocol. To ensure ongoing compliance the Human Rights Committee will monitor and make suggestions regarding facility practices at HRC meetings held every other month and on an as needed basis when needs arise. Coordinator and QMRP Responsible.	10/21/2012			

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	<p>bus and exited the bus with GHT #1, GHT #2, GHT #3, and GHT #4. Clients #1, #2, #3, #4, #5, #6, #7, and #8 went to and stood waiting at the five foot tall double latched access gate for the group home. At 3:55pm, GHT #1 stated client #5 "could possibly open" the double latched gated entry. GHT #1 stated clients #1, #2, #3, #4, #6, #7, and #8 "could not open" the double latched gate. At 5:50pm, GHT #1 indicated the double latched gated entry was in place for client safety from the busy street. GHT #1 indicated the double latched gate hardware was "only accessible from one side (of the gate)" which opened from the street side of the gate. At 6:30pm, the RM stated "I think [clients #4 and #5] could open the gate" to access the group home. The RM indicated clients #1, #2, #3, #6, #7, and #8 could not open the access gate independently.</p> <p>On 9/18/12 at 9:55am, client #1's record was reviewed. No documentation was available for review for client #1's restriction regarding the double latched access gate to the group home.</p> <p>On 9/18/12 at 9:20am, client #2's record was reviewed. No documentation was available for review for client #2's restriction regarding the double latched access gate to the group home.</p>			

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	<p>On 9/18/12 at 10:15am, client #3's record was reviewed. No documentation was available for review for client #3's restriction regarding the double latched access gate to the group home.</p> <p>On 9/18/12 at 10:50am, client #4's record was reviewed. No documentation was available for review for client #4's restriction regarding the double latched access gate to the group home.</p> <p>On 9/18/12 at 11:10am, an interview with the QMRP (Qualified Mental Retardation Professional) #1 and QMRP #2 was completed. QMRP #1 and QMRP #2 both indicated clients moved into this home in the spring of 2012 from other group homes within the agency. QMRP #1 and QMRP #2 both indicated no approvals or documented reviews from HRC for the restriction related to the double latched access gates were available for review for clients #1, #2, #3, #4, #5, #6, #7, and #8. Both QMRP #1 and QMRP #2 indicated the access gates opened from the street side of the gate and no latch for release was available from the yard side of the gate.</p> <p>On 9/18/12 at 11:10am, an interview with the Residential Coordinator (RC) was completed. The RC indicated the gate</p>				

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	<p>was a double latch mechanism and accessible from the street side of the gate. The RC indicated the double latch gate was secure, not accessible for clients, and a restriction. The RC indicated no HRC review and no HRC approval for the restricted access were available for review for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>9-3-4(a)</p>			

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation: Health Care Services, was not met as the facility failed to provide health care monitoring and oversight of nursing services for 1 of 4 sampled client (client #2) with an identified risk of seizures.</p> <p>Findings include:</p> <p>Please refer to W331. The facility's nursing services failed to provide oversight of client #2's medical needs during a transfer and to revise his seizure management plan for 1 of 4 sampled clients (client #2).</p> <p>Please refer to W340. The facility nursing services failed to ensure staff competently implemented training received on health care seizure interventions for 1 of 4 sampled clients (client #2) who had a seizure management plan.</p> <p>Please refer to W368. The facility's nursing services failed to ensure client #2 received his seizure medication as prescribed for 1 of 4 sampled clients (client #2).</p>	W0318	<p>The facility must ensure that specific health care services requirements are met. Cardinal Services strives to provide quality Health Care Services, monitoring and oversight of nursing services and to meet all of the provisions of Title XIX of the Social Security Act and be in compliance with each of the Conditions of Participation and other standards established by the Secretary of Health and Human Services. Throughout many years of service provision, Cardinal Services has demonstrated an excellent history of timely resolution of problems when identified. We are committed to remain in compliance to all Conditions and Standards, therefore have reviewed internal processes and systems related to these deficiencies. The corrective action taken by management, nursing personnel and support staff has resolved the problems identified during this survey. Systemic changes have been implemented that ensure ongoing compliance and monitoring for all persons served. See W331, W340 and W368.</p>	10/21/2012			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review, for 1 of 4 sampled clients (client #2), the facility's nursing services failed to provide oversight of client #2's medical needs during a transfer and to revise his seizure management plan.</p> <p>Findings include:</p> <p>On 9/17/12 at 11:55am, the facility's BDDS (Bureau of Developmental Services) Reports were reviewed for client #2.</p> <p>-A 8/8/12 BDDS report for an incident on 4/23/12 at 9pm, indicated client #2's previous group home burned down and client #2 was moved to the Parker Street group home. The report indicated on 3/8/12 client #2's Neurologist ordered Vimpat 50mg (milligrams) medication "for breakthrough seizures." The report indicated "the Parker Street staff were unaware of this order, [the Pharmacy] did not deliver or fill this medication with the other post fire medications, and it never appeared on [client #2's] MAR (Medication Administration Record) or [client #2's] 90 day (Physician) orders." The report indicated client #2 "had not received this medication since</p>	W0331	<p>W331</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>The facility nurse has provided oversight for the revision of Client #2 seizure plan with current information. (See attachment N) Staff were trained on this revised plan and where to locate information by October 1, 2012. (See attachment O)</p> <p>The Medication Administration Policy has been amended to include protocol that ensures medication orders are filled according to doctor's orders. This protocol will prevent future errors in medication administration even in disaster situations. (See attachment P) Nurses and Residential Managers were trained on this Policy Revision on September 28, 2012 (see attachment Q) In order to ensure overall agency compliance, agency staff will receive training regarding this policy revision by October 7, 2012.</p> <p>To ensure ongoing compliance nurses will compare previous month's MAR to current month for</p>	10/07/2012			

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	<p>4/23/12...Cardinal Nursing has spoken with the Neurologist who wants to restart Vimpat 50mg twice daily as ordered...."</p> <p>-A 8/16/12 follow up BDDS report indicated "the Residential Manager, Residential Nurse, and the Pharmacy are responsible to ensure that all medication orders are filled according to doctor's orders. As medications come into the group home staff check them in using the current Medication Administration Record (MAR), and doctor's orders to ensure for accuracy and that all medications are available." The report indicated "the team does not view this as neglect. An investigation was initiated to determine the cause of this incident. The missed medication had been started on 3/8/12 and had been hand written as per policy (sic) on the MAR. When the April MAR was generated by the pharmacy (then) came into the home the order for Vimpat was not included and was entered by hand. On 4/23/12 a fire destroyed the home...the original MAR's, and medications were lost in the fire. Copies of [client #2's] MAR were obtained from the Day Program and taken to the Parker Street group home. The Day Program MAR did not include the new order for the Vimpat as this was a medication that was only given in the home. The pharmacy refilled all of [client #2's]</p>		<p>accuracy. Pharmacist will complete pharmacy reviews quarterly.</p> <p>Coordinator, Manager, Nurse and Pharmacist responsible.</p>				

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	<p>medications per their electronic records and for some reason the system had kicked out (the pharmacy's system did not generate) the order for the Vimpat...During the monthly review the nurse did not observe that the medication was not on the MAR (5/2012) because the medication was also not on the 90 day physician's order. When May medications were prepared for the home by the pharmacy the order for the Vimpat was not in the computer system and therefore, not filled...This is why the error took so long to be discovered. While checks and balances are in place, they did not prevent this error in a disaster situation. In order to prevent this type of error in the future, any time an internal transfer for persons served takes place" an existing staff will be with the client during the transfer. The report indicated "Lastly, all new medication orders will be entered onto the Day Program MARs whether the person will receive that medication while they attend Day Program or not..."</p> <p>On 9/17/12 at 1:55pm, an interview was conducted with the Residential Coordinator (RC) and the Agency Licensed Practical Nurse (LPN). Both indicated client #2 had an order from client #2's neurologist on 3/8/12 for Vimpat 50mg twice daily. Both indicated</p>			

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	<p>client #2 received the medication from 3/8/12 until 4/23/12. Both indicated client #2 did not receive the medication from 4/23/12 until 8/8/12 when the medication omission had occurred and was discovered by the pharmacist and the agency LPN within minutes of one another during separate audits of client #2's record on 8/8/12. The LPN stated she compared client #2's MAR "for one month to the MAR from the last month, then reconciled" to client #2's 90 physician's order when she monitored medications. The LPN indicated client #2's workshop MAR was used to hand write client #2's MAR for use at Parker Street group home after the fire on 4/23/12. The LPN indicated she did not recheck client #2's medications to ensure all medication orders were on the new MAR at Parker Street. The LPN stated she "knew" that workshop MARs did not include "all" medications used by the client. The LPN indicated she had compared client #2's 5/2012 MAR to his physician's orders which did not have the Vimpat medication listed. The LPN indicated client #2's 3/8/12 Physician's order for the Vimpat 50mg twice daily medication was available in client #2's record at the agency.</p> <p>On 9/18/12 at 9:20am, client #2's record was reviewed. Client #2's 3/2012 MAR</p>			

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	<p>indicated hand written on the MAR "Vimpat 100mg tablet take 1/2 tablet twice daily for seizures" and the 3/2012 MAR indicated started 3/9/12, administered from 3/9/12 through 3/31/12. Client #2's "90 day Physician's Order" signed by client #2's physician on 7/26/12, indicated a handwritten "Vimpat 50mg bid P.O. (by mouth) (dated) 3/8/12 (for) seizures." Client #2's record included on 3/8/12 was seen by his neurologist who ordered "Vimpat 50mg bid, take pt. (patient) to E.R. (Emergency Room) for seizures lasting longer than 20 minutes. Return visit 3 months." Client #2's record indicated "Nursing Quarterly Physical Assessments" dated 8/24/12 noted no problems. Client #2's 5/23/12 "Physician Examination" 450B, indicated "neurology follow up for seizure disorder and signed by client #2's physician. Client #2's 10/12/11 "Seizure Management Plan" indicated he had grand mal seizures, received routine medications, did not include the Vimpat medication for breakthrough seizures, did not include client #2's neurology order for "take to ER for seizure lasting longer than 20 minutes."</p> <p>On 9/18/12 at 9:20am, client #2's Seizure Log was reviewed with the Residential Coordinator (RC) and indicated the following seizures:</p>						

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	<p>-On 9/17/12 at 5:44 (no am/pm), duration 1 minute (min.) 28 seconds (sec.), was unconscious, and jerked.</p> <p>-On 9/4/12 at 4:54 (no am/pm), duration 7 minutes, jerked, and was rigid.</p> <p>-On 8/31/12 at 3:53pm, duration 2 minutes, jerked, and was incontinent.</p> <p>-On 8/28/12 at 5:59 (no am/pm), duration 7 minutes 30 seconds, unconscious, and was incontinent.</p> <p>-On 8/28/12 at 4:04am, duration 4 minutes, semi responsive, and jerked.</p> <p>-On 8/27/12 at 4:57pm, duration 5 minutes, unconscious and incontinent.</p> <p>-On 8/16/12 at 7pm, duration 3 minutes, unconscious, rigid, and jerked.</p> <p>-On 8/14/12 at 5:55pm, duration 2 minutes 18 seconds, semi responsive, and jerked.</p> <p>-On 8/12/12 at 6:55pm, duration 7 minutes 10 seconds, unconscious and jerked.</p> <p>-On 8/8/12 at 7:14 (no am/pm), duration 2 minutes 42 seconds, rigid, and jerked.</p> <p>-On 7/31/12 at 6:58pm, duration 2 minutes, jerked.</p> <p>-On 7/31/12 at 5:20pm, duration 4 minutes 30 seconds, jerked.</p> <p>-On 7/31/12 at 4:45pm, duration 5 minutes 40 seconds, semi responsive, and jerked.</p> <p>-On 7/27/12 at 8:55 (no am/pm), duration 6 minutes, semi responsive, jerked, and incontinent.</p>			

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	<p>-On 7/23/12 at 7:45pm, duration 8 minutes, semi responsive, rigid, and jerked.</p> <p>-On 7/6/12 at 8:20pm, duration 4 minutes 10 seconds, unconscious, and jerked.</p> <p>-On 7/5/12 at 7:21am, duration 1 min. 6 seconds, semi responsive, and jerked.</p> <p>-On 7/4/12 at 2:11pm, duration 4 minutes, unconscious, rigid, jerked, and was incontinent.</p> <p>-On 7/4/12 at 12:30pm, duration 1 minute 45 seconds, unconscious, and jerked.</p> <p>-On 7/3/12 at 6:55am, duration 7 minutes 35 seconds, unconscious, and jerked.</p> <p>-On 6/27/12 at 7:20pm, duration 6 minutes 20 seconds, semi responsive, and jerked.</p> <p>-On 6/26/12 at 6:13am, duration 3 minutes 42 seconds, unconscious, rigid, and jerked.</p> <p>-On 6/23/12 at 5:32pm, duration 5 minutes 52 seconds, semi responsive, and jerked.</p> <p>-On 6/20/12 at 7:05pm, duration 3 minutes, unconscious and jerked.</p> <p>-On 6/19/12 at 7:30pm, duration 4 minutes, unconscious, rigid, and jerked.</p> <p>-On 6/19/12 at 5:10pm, duration 1 minute 5 seconds, semi responsive, and jerked.</p> <p>-On 6/18/12 at 7:49pm, duration 6 minutes 40 seconds, semi responsive.</p> <p>-On 6/18/12 at 5:25pm, duration 2 minutes 42 seconds, semi responsive and jerked.</p>			

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	<p>-On 6/16/12 at 7:10pm, duration 16 minutes 35 seconds, semi responsive, and jerked.</p> <p>-On 6/11/12 at 7:15am, duration 7 minutes 30 seconds, semi responsive, and jerked.</p> <p>-On 6/6/12 at 6:15pm, duration 7 minutes 16 seconds, semi responsive, and jerked.</p> <p>-On 5/22/12 at 7:10pm, duration 5 minutes, semi responsive, and jerked.</p> <p>-On 5/17/12 at 7:55pm, duration 3 minutes 50 seconds, semi responsive, and jerked.</p> <p>-On 5/12/12 at 6:55pm, duration 9 minutes 45 seconds, semi responsive, and jerked.</p> <p>-On 5/6/12 at 3:15pm, duration 11 minutes, and jerked.</p> <p>-On 4/24/12 at 7:10pm, duration 5 minutes 12 seconds, semi responsive, and jerked.</p> <p>On 9/18/12 at 12:17pm, an interview was conducted with the RC. The RC indicated client #2's seizure intensity had increased from 4/23/12 until his Vimpat medication for "breakthrough" seizures was restarted on 8/8/12. The RC indicated no additional seizure logs were available for review. The RC indicated client #2's Seizure Management Plan had not been updated to include the neurologist orders for Vimpat or to take to ER for seizures lasting over 20 minutes.</p>			

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	<p>On 9/18/12 at 2pm, the facility's 7/2012 "Medication Policy" was reviewed. The policy indicated "...20.0 Prescription Medication...20.3 The original Physician's order is filed in the main file at Cardinal Services or routed to the satellite day service...25.0 Record of Medication...25.6 The nurse shall maintain a medication history of all residential persons served in the MRDD (Agency) system...."</p> <p>9-3-6(a)</p>			

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W0340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on observation, record review, and interview, the facility nursing services failed to ensure staff competently implemented training received on health care seizure interventions for 1 of 4 sampled clients (client #2) who had a seizure management plan.</p> <p>Findings include:</p> <p>During observations on 9/18/12 from 5:50am until 6:40am, client #2 was in the group home. At 6:15am, GHT (Group Home Trainer) #6 sat next to client #2 at the dining room table. At 6:15am, GHT #6 indicated client #2 had "breakthrough seizures" and had experienced a "breakthrough seizure" on 9/17/12 at 5:45pm. At 6:20am, client #2 went with GHT #1 to the medication room for morning medication. At 6:20am, GHT #1 stated if client #2 had "seizures longer than ten (ten) minutes" she would call 9-1-1 and call the nurse. GHT #1 stated and showed client #2's 7/26/12 "90 day Physician's Order" which indicated "10</p>	W0340	<p>W 340 Nursing Services must include implementing with other members of the interdisciplinary team, appropriate protective and preventative health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Cardinal Services believes strongly in providing Direct Support Professionals with current, relative and effective resource information to ensure that they are able to provide all necessary supports for those they serve. To comply with this belief Direct Support Professionals are trained on all support needs for persons served prior to working with them. (See Attachment R) All information regarding client supports is made available in each group home. To ensure that staff in the Parker St. group home know where to locate these resources they received additional training advising them of where this information is located on September 21, 2012. (See Attachment S) To ensure that all group home staff are able to locate client information, all</p>	10/07/2012			

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	<p>minute seizure protocol." GHT #1 indicated no additional seizure information was available for review. At 7:30am, GHT #6 sat next to client #2 at the dining room table eating breakfast. GHT #6 indicated client #2 had a seizure protocol, accessed client #2's program book, and showed client #2's 7/26/12 "90 day Physician's order...10 minute seizure protocol." GHT #6 indicated no further seizure information was available at the group home for review.</p> <p>On 9/18/12 at 9:20am, client #2's record was reviewed. Client #2's 7/26/12 "90 day Physician's Order" signed by client #2's physician, indicated a handwritten "Vimpat 50mg bid P.O. (by mouth) (dated) 3/8/12 (for) seizures...10 minute seizure protocol." Client #2's record included on 3/8/12 was seen by his neurologist who ordered "Vimpat 50mg bid, take pt. (patient) to E.R. (Emergency Room) for seizures lasting longer than 20 minutes. Return visit 3 months." Client #2's 10/12/11 "Seizure Management Plan" indicated he had grand mal seizures, received routine medications, did not include the Vimpat medication for breakthrough seizures, and did not include client #2's neurology order for "take to ER for seizure lasting longer than 20 minutes." Client #2's 10/12/11 "Seizure Management Plan" indicated "if</p>		<p>staff will receive additional training regarding where to locate client binders in the home they work in by October 7, 2012. On September 28, 2012 Client #2's seizure plan was revised to reflect that staff should take Client #2 to the E.R. for seizures lasting more than 20 minutes. (See Attachment N) To ensure that Direct Support Professionals are fully aware of this revised protocol, staff will be trained on the plan revision by October 5, 2012. (See Attachment O) On October 1, 2012 QDP's received training stating that all risk plans must be updated in a timely manner. (See Attachment T) To ensure that these deficiencies do not occur in the future staff competency will be monitored by weekly, monthly and quarterly observation by the Residential Manager, QDP and Residential Coordinator. Additionally, support plans will be monitored by ongoing monthly and quarterly document review by the Residential Manager and Residential Coordinator. QDP, Residential Manager and Residential Coordinator Responsible</p>				

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	<p>longer than 10 minutes call 9-1-1."</p> <p>On 9/18/12 at 12:17pm, an interview was conducted with the RC. The RC indicated client #2's seizure intensity had increased from 4/23/12 until his Vimpat medication for "breakthrough" seizures was restarted on 8/8/12. The RC indicated client #2's 10/12/11 "Seizure Management Plan" was in a separate location at the group home and staff did not access that information. The RC indicated when client #2 had seizures it would be important for staff to know what the physician had recommended. The RC indicated client #2's Seizure Management Plan had not been updated to include the 3/8/12 neurologist orders for Vimpat or to take to ER for seizures lasting over 20 minutes.</p> <p>9-3-6(a)</p>			

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W0368	<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.</p> <p>Based on interview and record review, for 1 of 4 sampled clients (client #2), the facility's nursing services failed to ensure client #2 received his seizure medication as prescribed.</p> <p>Findings include:</p> <p>On 9/17/12 at 11:55am, the facility's BDDS (Bureau of Developmental Services) Reports were reviewed for client #2.</p> <p>-A 8/8/12 BDDS report for an incident on 4/23/12 at 9pm, indicated client #2's previous group home burned down and client #2 was moved to the Parker Street group home. The report indicated on 3/8/12 client #2's Neurologist ordered Vimpat 50mg (milligrams) medication "for breakthrough seizures." The report indicated "the Parker Street staff were unaware of this order, [the Pharmacy] did not deliver or fill this medication with the other post fire medications, and it never appeared on [client #2's] MAR (Medication Administration Record) or [client #2's] 90 day (Physician) orders." The report indicated client #2 "had not received this medication since</p>	W0368	<p>W 368</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Cardinal Services has a history of providing premier services for those we support that includes thorough medical oversight. To ensure that all prescribed medications are available for each person we support on a day-to-day basis and in disaster situations, the Cardinal Services Medication Policy was revised to outline a more reliable system for nursing oversight regarding medication availability. (See Attachment P) Nursing staff and Residential Managers were trained on this policy revision on September 28, 2012. (See Attachment Q) To ensure over all agency compliance Cardinal Services staff will receive training on this policy update by October 5, 2012.</p> <p>To ensure this deficiency does not occur in the future nursing personnel will observe the revised policy update. Pharmacy review will be completed quarterly that includes the review of Medication</p>	10/07/2012			

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	<p>4/23/12...Cardinal Nursing has spoken with the Neurologist who wants to restart Vimpat 50mg twice daily as ordered...."</p> <p>On 9/17/12 at 1:55pm, an interview was conducted with the Residential Coordinator (RC) and the Agency Licensed Practical Nurse (LPN). Both indicated client #2 had an order from client #2's neurologist on 3/8/12 for Vimpat 50mg twice daily. Both indicated client #2 received the medication from 3/8/12 until 4/23/12. Both indicated client #2 did not receive the medication from 4/23/12 until 8/8/12 when the medication omission had occurred. The LPN stated she compared client #2's MAR "for one month to the MAR from the last month, then reconciled" to client #2's 90 physician's order when she monitored medications. The LPN indicated client #2's workshop MAR was used to hand write client #2's MAR for use at Parker Street group home after the fire on 4/23/12. The LPN indicated she did not recheck client #2's medications to ensure all medication orders were on the new MAR at Parker Street. The LPN stated she "knew" that workshop MARs did not include "all" medications used by the client. The LPN indicated she had compared client #2's 5/2012 MAR to his physician's orders which did not have the Vimpat medication listed. The LPN</p>		<p>Administration Records for accuracy</p> <p>Nursing Personnel and Pharmacist Responsible</p>				

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	<p>indicated client #2's 3/8/12 Physician's order for the Vimpat 50mg twice daily medication was available in client #2's record at the agency.</p> <p>On 9/18/12 at 9:20am, client #2's record was reviewed. Client #2's 3/2012 MAR indicated hand written on the MAR "Vimpat 100mg tablet take 1/2 tablet twice daily for seizures" and the 3/2012 MAR indicated started 3/9/12, administered from 3/9/12 through 3/31/12. Client #2's "90 day Physician's Order" signed by client #2's physician on 7/26/12, indicated a handwritten "Vimpat 50mg bid P.O. (by mouth) (dated) 3/8/12 (for) seizures." Client #2's record included on 3/8/12 was seen by his neurologist who ordered "Vimpat 50mg bid." Client #2's 10/12/11 "Seizure Management Plan" indicated he had grand mal seizures, received routine medications and did not include the Vimpat medication for breakthrough seizures.</p> <p>On 9/18/12 at 12:17pm, an interview was conducted with the RC. The RC indicated client #2's seizure intensity had increased from 4/23/12 until his Vimpat medication for "breakthrough" seizures was restarted on 8/8/12. The RC indicated client #2's Seizure Management Plan had not been updated to include the</p>			

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	<p>neurologist orders for Vimpat.</p> <p>On 9/18/12 at 2pm, the facility's 7/2012 "Medication Policy" was reviewed. The policy indicated "...20.0 Prescription Medication...20.3 The original Physician's order is filed in the main file at Cardinal Services or routed to the satellite day service...25.6 The nurse shall maintain a medication history of all residential persons served in the MRDD (Agency) system...." The policy indicated clients should be provided their prescribed medications.</p> <p>9-3-6(a)</p>			

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT 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, interview, and record review, for 2 of 2 clients (clients #2 and #8) who used wheel chairs, the facility failed to maintain client #2 and #8's wheelchair arm rests and seat backs in good repair.</p> <p>Findings include:</p> <p>On 9/17/12 from 3:45pm until 6:40pm, and on 9/18/12 from 5:50am until 7:45am, client #2 sat in a wheel chair moved throughout the group home and two of two (2 of 2) arm rests and the back seat on client #2's wheel chair had the vinyl covering torn and padding exposed. On 9/18/12 at 6:40am, GHT (Group Home Trainer) #6 indicated client #2's wheel chair had both arm rests and the seat back vinyl torn and padding exposed. GHT #6 stated client #2 "uses his wheel chair everyday." At 7:10am, the Residential Manager stated client #2's wheel chair had been "like that" since admission to the group home on 4/23/12.</p>	W0436	<p>W 436</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>Cardinal Services is committed to providing all equipment necessary to enhance the lives and independence for those we support. Client #8 received his new electric wheelchair on Friday, September 21, 2012. The QDP for Client #2 is in the process of obtaining his new wheel chair. To ensure that adaptive equipment, including wheelchairs, is maintained and serviceable, Direct Support staff will conduct routine Adaptive Equipment Checks for all adaptive equipment and report all concerns to the QDP. (See Attachment U) In addition, the Residential Manager will complete a record review monthly to ensure that all adaptive</p>	10/07/2012			

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	<p>On 9/18/12 at 7:10am, the Residential Manager (RM) assisted client #8 out of his bed using a hooyer lift to transfer client #8 into his wheel chair. The RM stated client #8's wheel chair seat back had a "split" six (6) inches long, exposed the padding and wooden supports of client #8's wheel chair. The RM stated client #8's wheel chair had been "like that" since admission to the group home on 4/23/12. At 7:20am, GHT #1 and GHT #6 indicated client #8's vinyl tears in his wheel chair seat back exposed the padding and wood.</p> <p>Client #2's record was reviewed on 9/18/12 at 9:20am. Client #2's 7/26/12 "90 day Physician's Order" indicated an order to use a wheel chair. Client #2's 10/12/11 ISP (Individual Support Plan) indicated client #2 used a wheel chair.</p> <p>An interview with the Residential Coordinator (RC) was conducted on 9/18/12 at 12:30pm. The RC indicated clients #2 and #8 used wheel chairs daily for their mobility. The RC stated client #8's "new wheel chair should be delivered Friday (9/21/12)" and she was unaware of client #2's wheel chair needing repair.</p> <p>9-3-7(a)</p>		<p>equipment concerns have been addressed. (See Attachment V) The QDP will receive the Adaptive Equipment checklist monthly and review for all concerns. The QDP will ensure all repairs or replacements are completed on a timely basis to ensure that each person has the equipment necessary meet all of their daily needs. Direct Support Professionals, Residential Managers and QDP's will receive training on the Adaptive Equipment Check by October 5, 2012. (See Attachment W)</p> <p>To ensure this deficiency does not occur in the future, the Residential Manager and Residential Coordinator will monitor adaptive equipment through weekly, monthly and quarterly document review and observation.</p> <p>Residential Manager and Residential Coordinator Responsible</p>				