STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL SERVICES INC OF INDIANA	1109 N PARK AVE WARSAW, IN 46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for the investigation of complaint #IN00135824. COMPLAINT #IN00135824-SUBSTANTIATED. Federal/State deficiencies related to the allegation are cited at W149 and W249. Dates of Survey: October 9, 10 and 11, 2013. Facility number: 003172 Provider number: 15G695 Aim number: 200361630 Surveyor: Kathy Wanner, QIDP. These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed October 22, 2013 by Dotty Walton, QIDP.	W000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W000149	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 record review and interview, the facility failed to assure direct care staff (DCS) followed the facility's Incident/Abuse/Neglect Policy for 3 of 4 sampled clients (clients A, B and C) as indicated in 3 of 3 allegations of abuse/neglect reviewed. Findings include: Facility records were reviewed on 10/9/13 at 3:20 P.M. including the Bureau of Developmental Disabilities Services (BDDS) Reports for the time period between 8/1/13 and 10/9/13. The BDDS reports indicated the following: 1. A BDDS report dated 8/29/13 for an incident on 8/28/13 at 8:00 P.M. indicated "[DCS #10] was administering medications for [client A]. [Client A] refused his medications and in the process his liquid medication spilled over his clothing. [DCS #10] took the blanket that [client A] had been carrying in an attempt to coax him into the bathroom to assist him with changing his dirty clothing. When in the bathroom, [client A] refused to remove his dirty clothing. [DCS #10] used the shower hose to spray [client A]	W000149	W149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. To prevent additional incidents DCS #10 was terminated on August 29, 2013 due to her involvement in incidents with client A and client B (See attachment A.) Staff working with client C received additional training outlining client C's Self-Management plan/Toileting Schedule on August 22, 2013 (See attachment B.) In addition, to assure that the people living in the Park Avenue group home are free from abuse, mistreatment and neglect, the support staff at the Park Avenue group home will receive additional training regarding Cardinal Services' Client Rights and Demeaning Tactics (See attachment C.) Failure to follow will result in an incident report and disciplinary action as appropriate. To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the staff performance through weekly, monthly and quarterly observations (See observation E.) Coordinator, Manager and QDPs Responsible	11/09/2013

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	down while standing fully dressed in the middle of his bathroom. [DCS #10] stated that she did not find a problem with this action as she was making sure he was clean. [DCS #10] did not ask for assistance from other staff in the home. [DCS #10] was terminated from Cardinal Services on 8/29/13." A BDDS follow-up report dated 9/5/13 indicated "[Client A] seems to be doing well and to not have suffered any negative outcomes as a result of this incident. [Client A] received counseling to assure him that this would not happen again. An investigation determined that neither [client A] nor his peers had suffered this type of treatment prior to this incident." The facility's internal investigation summary dated 8/29/13 was reviewed on 10/9/13 at 4:31 P.M. The report indicated "It has been determined that this staff action was mistreatment and therefore abusive. [DCS #10] was terminated on 8/29/13." 2. A BDDS report dated 8/21/13 for an incident on 8/20/13 at 1:00 P.M. indicated "Staff failed to assist [client C] in using the restroom every two hours, allowing him to go from 8:30 A.M. - 1:00 P.M. without use of the restroom. Staff attempted to assist [client C], however he			

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	refused becoming combative...staff failed to utilize all resources by not contacting another staff to assist." A BDDS follow-up report dated 8/26/13 indicated "...staff received additional training regarding [client C's] plan which included non-compliance, dignity and respect...as the staff (unknown) was being interviewed regarding the incident she was able to recite [client C's] plan but then stated that he was hitting her and he chose to not use the restroom. This staff resigned her position immediately. Cardinal Services deemed this incident as neglect." 3. A BDDS report dated 8/20/13 for an incident on 8/20/13 6:30 A.M. indicated "[Client B] fell while preparing to use the bathroom. This fall resulted in a small reddened area on [client B's] head that has persisted through the day...[Client B] has a helmet that he is to wear during all waking hours and staff did not follow this schedule and [client B] was not wearing his helmet." A follow-up BDDS report dated 8/26/13 indicated "Staff was standing in front of [client B] at the time of this accident. [Client B] began to sit on the toilet and misjudged his placement and slipped off the seat, bumping his head on the grab bar			

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	next to the toilet. Staff (DCS #10) had been trained on [client B's] risk plans prior to working with him and often assist's (sic) [client B] with preparing for his day. This staff was able to recite [client B's] risk plans at the time of her interview and stated that on this particular morning she forgot to assist him with his helmet prior to [client B] getting out of his bed. To prevent future falls this staff (DCS #10) received additional training regarding the implementation of [client B's] plans and disciplinary action for failure to implement the plan as written." A BDDS follow-up report dated 8/26/13 indicated "Staff (DCS #10) that was suspended as a result of this incident was found to be negligent in not following [client B's] risk plan when she did not assist him with wearing his helmet prior to exiting his bed." The facility's Agent Code of Ethics dated 6/2013 was reviewed on 10/11/13 at 3:38 P.M. and indicated "6.0 It is my responsibility to follow designated medical treatment and clinical, educational or training plans and that failure to do so will be considered neglect of duty...." The facility's Incident/Abuse/Neglect Policy dated 2013-2014 was reviewed on			

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	10/11/13 at 3:49 P.M. and 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; incidents will be reported and thoroughly investigated as outlined in this policy. 2.1 Physical Abuse/Sexual Abuse: This includes, forced physical activity, willful infliction of injury, by hitting, pinching, or kicking, physical restraints, using painful noxious stimuli or electric shock or isolation, unnecessary chemical restraints, punishment with resulting physical harm or pain, allegation of rape, sexual misconduct, or sexual exploitation...2.4 Neglect: Incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support, including food, drink, clothing, shelter, sleep, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities)." The Residential Manager (RM) was interviewed on 10/9/13 at 6:19 P.M. When asked if staff had followed facility			

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	policy, the RM stated, "I don't think [DCS #10] dealt with any of the policies correctly." The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 10/9/13 at 4:50 P.M. The QIDP indicated staff had not followed the facility's policies. This federal tag relates to complaint #IN00135824. 9-3-2(a)			

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on record review and interview, the facility failed to assure the individualized needed interventions for 3 of 4 sampled clients (clients A, B and C) were consistently implemented to protect and support client achievement. Findings include: Facility records were reviewed on 10/9/13 at 3:20 P.M. including the Bureau of Developmental Disabilities Services (BDDS) Reports for the time period between 8/1/13 and 10/9/13. The BDDS reports indicated the following: 1. A BDDS report dated 8/29/13 for an incident on 8/28/13 at 8:00 P.M. indicated "[DCS #10] was administering medications for [client A]. [Client A] refused his medications and in the process his liquid medication spilled over his clothing. [DCS #10] took the blanket that [client A] had been carrying in an attempt to coax him into the bathroom to assist him with changing his dirty clothing.	W000249	W249 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. To prevent additional incidents DCS #10 was terminated on August 29, 2013 due to her involvement in incidents with client A and client B (See attachment A.) Staff working with client C received additional training outlining client C's Self-Management plan/Toileting Schedule on August 22, 2013 (See attachment B.) In addition, to assure that the people living in the Park Avenue group home are free from abuse, mistreatment and neglect, the support staff at the Park Avenue group received additional training regarding Cardinal Services' Client Rights and Demeaning Tactics (See attachment C.) Staff have received additional	11/09/2013

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	When in the bathroom, [client A] refused to remove his dirty clothing. [DCS #10] used the shower hose to spray [client A] down while standing fully dressed in the middle of his bathroom. [DCS #10] stated that she did not find a problem with this action as she was making sure he was clean. [DCS #10] did not ask for assistance from other staff in the home. [DCS #10] was terminated from Cardinal Services on 8/29/13." The facility's internal investigation summary dated 8/29/13 was reviewed on 10/9/13 at 4:31 P.M. The report indicated "It has been determined that this staff action was mistreatment and therefore abusive. [DCS #10] was terminated on 8/29/13." Client A's record was reviewed on 10/10/13 at 1:15 P.M. Client A's record included a Self Management Plan (SMP) dated 12/6/12 which indicated "If I should refuse the request/activity, staff will state that they will ask me again in a few minutes and to be prepared to begin the activity. I seem to need ample time to respond to requests. If I begin the activity staff should be sure to praise me and thank me for making the right choice. If I still refuse the request, staff should again state that they will ask me in a few minutes and when they return they would		training on update Fall Risk Plans on 8/28/13 reiterating that Client B is to be wearing his helmet through all waking hours, regardless of the distance walking or amount of time awake (See attachment D.) To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the staff performance through weekly, monthly and quarterly observations (See observation E.) QDP, Residential Manager and Coordinator Responsible.	

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	like me to begin the activity. If I continue to refuse staff should not ask me again...staff may hand the object to me...Another method would be to have a different staff prompting me to change. Sometimes I will complete a task for one staff member and not another." 2. A BDDS report dated 8/21/13 for an incident on 8/20/13 at 1:00 P.M. indicated "Staff failed to assist [client C] in using the restroom every two hours, allowing him to go from 8:30 A.M. - 1:00 P.M. without use of the restroom. Staff attempted to assist [client C], however he refused becoming combative...staff failed to utilize all resources by not contacting another staff to assist." A BDDS follow-up report dated 8/26/13 indicated "...staff received additional training regarding [client C's] plan which included non-compliance, dignity and respect...as the staff (unknown) was being interviewed regarding the incident she was able to recite [client C's] plan but then stated that he was hitting her and he chose to not use the restroom. This staff resigned her position immediately. Cardinal Services deemed this incident as neglect." Client C's record was reviewed on 10/10/13 at 2:58 P.M. Client C's			

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	Individual Support plan (ISP) dated 4/29/13 included the following objective "Will complete toileting every two hours. Staff will ensure that I use the toilet every 2 (two) hours per toileting schedule. Once I have completed the toileting process please give me prompts up to what I will tolerate to flush the toilet, wash my hands, etc." Client C's Self Management Plan (SMP) dated 1/4/13 indicated client C may refuse to get up to use the restroom. "If I am having difficulties with one staff, staff will rotate to assist me through the transition time." 3. A BDDS report dated 8/20/13 for an incident on 8/20/13 6:30 A.M. indicated "[Client B] fell while preparing to use the bathroom. This fall resulted in a small reddened area on [client B's] head that has persisted through the day...[Client B] has a helmet that he is to wear during all waking hours and staff did not follow this schedule and [client B] was not wearing his helmet." A follow-up BDDS report dated 8/26/13 indicated "Staff was standing in front of [client B] at the time of this accident. [Client B] began to sit on the toilet and misjudged his placement and slipped off the seat, bumping his head on the grab bar next to the toilet. Staff (DCS #10) had been trained on [client B's] risk plans			

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	prior to working with him and often assist's (sic) [client B] with preparing for his day. This staff was able to recite [client B's] risk plans at the time of her interview and stated that on this particular morning she forgot to assist him with his helmet prior to [client B] getting out of his bed. To prevent future falls this staff (DCS #10) received additional training regarding the implementation of [client B's] plans and disciplinary action for failure to implement the plan as written." A BDDS follow-up report dated 8/26/13 indicated "Staff (DCS #10) that was suspended as a result of this incident was found to be negligent in not following [client B's] risk plan when she did not assist him with wearing his helmet prior to exiting his bed...In addition, an order was obtained from [client B's] physician for a gait belt to be used during all transfers." Client B's record was reviewed on 10/10/13 at 2:05 P.M. Client B's record included a Risk Plan dated 9/16/13. The plan indicated "The helmet should be on at all times regardless of being in a wheelchair or not...assist with putting on the helmet and gait belt and/or assist with transferring into the wheelchair.' Client B's Care Plan dated 9/30/13 indicated "Client will wear gait belt and helmet			

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	during all transfers and when ambulating." DCS #1 was interviewed on 10/9/13 at 5:28 P.M. DCS #1 stated, "He (client B) was to wear his helmet at all times, any time he would/could stand up. [Client C] was to use the restroom at least every two hours." DCS #1 indicated she sometimes moves (client A) to the bathroom to see if he will stand up from his wheelchair. DCS #3 was interview on 10/9/13 at 5:45 P.M. DCS #3 stated, "I always get another staff if [client B] refuses to use the restroom. [Client B] should wear his helmet all the time. I ask [client A], and if he refuses I wait awhile or play some music. I get help from other staff, they may have better luck then me." DCS #4 was interviewed on 10/9/13 at 5:41 P.M. DCS #4 indicated client C was to use the restroom every two hours, if he refused she would wait a few minutes or get another staff. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 10/9/13 at 4:50 P.M. The QIDP indicated staff had not followed client A, client B and client C's plans. This federal tag relates to complaint			

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