

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  01/03/2013
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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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W0000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Dates of survey: December 19, 20, 21, 2012, and January 2 and 3, 2013.</p> <p>Surveyor: Kathy J. Wanner, Medical Surveyor III</p> <p>Provider number: 15G392 Facility number: 000906 AIM number: 100235160</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 1/10/13 by Ruth Shackelford, 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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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>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, the facility failed to ensure all medications were administered in compliance with 1 of 4 sampled clients (client #4's) physician's orders.</p> <p>Findings include:</p> <p>Facility records were reviewed on 12/19/12 at 2:40 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following:</p> <p>A BDDS report dated 12/30/11 for 12/29/11 at 8:00 P.M. indicated "On 12/29/11 at 8:00 P.M. [client #4] was given the medication Tenex (Attention Deficit Hyperactivity Disorder or Hypertension) 3 mg (three milligrams). This medication had already been given at the scheduled time of 4:00 P.M.. This mistake was discovered immediately and the nurse and Residential Manager were contacted. As instructed by the nurse [client #4's] vitals were monitored every 2 (two) hours."</p> <p>A BDDS report dated 8/6/12 for 8/4/12 at</p>	W0368	<p><b>W 368</b></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 is committed to ensuring that all medications are administered to the people that we support as ordered by their physician.</p> <p>Staff responsible for administering an extra dose of medication on December 29, 2011 received additional training regarding how to complete error free medication administration and disciplinary action. On August 21, 2012 staff responsible for the medication errors that occurred on August 4, 2012 and August 5, 2012 received disciplinary action and were required to attend Core A Medication Administration Class where training was provided regarding the proper administration of medications and they were required to complete an error free medication administration under observation. <b>(See Attachment A)</b></p>	02/02/2013	

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	<p>6:00 A.M. indicated "On 8/4/12 and on 8/5/12 during the 6:00 A.M. medication pass. [Client #4] was given two doses of her medication Protonix (esophagus/reflux) 40 mg (forty milligrams) instead of the prescribed one dose. A new pack of her Protonix was accidentally placed in with her med's (medication) before the old pack had been completed. The extra pill pack was found by staff on 8/6/12 during the morning medication pass and this is when the error was discovered...."</p> <p>A BDDS report dated 10/12/12 for 10/12/12 at 12:00 P.M. indicated "... [client #4] was given a peer's medication instead of her own. She received Lorazepam (anti-anxiety) 1 mg (one milligram) in place of her prescribed medication Clonazepam (anti-anxiety) 0.5 mg (one half of a milligram). Residential nurse was notified, as was PCP (primary care physician) by fax. Vitals were checked...."</p> <p>An interview was conducted with LPN #1 on 1/3/13 at 12:55 P.M. LPN #1 stated, "Staff didn't do checks properly." LPN #1 indicated the facility had developed a new system for medication errors. "After staff are given a medication error they are observed by the nurse or the residential manager, coordinator, or QDDP</p>		<p>On October 15, 2012 staff that administered a peer's medication to client #4 received additional training regarding how to complete error free medication administration and disciplinary action. <b>(See Attachment B)</b> On October 16, 2012 this same staff was required to complete an error free medication administration under observation prior to passing medications unsupervised once again. <b>(See Attachment C)</b> In May 2012 a system was developed to assess staff competency when administering medication after committing a medication error. This system requires that staff complete an error free medication administration following all six rights of administration while being supervised by the Residential Manager, QDP, Nurse or Residential Coordinator prior to being allowed to administer medications unsupervised. <b>(See Attachment D)</b> In order to assure consistency throughout the agency and to prevent this deficiency from occurring in the future this system will be formally added to Cardinal Services' Medication Error Policy by February 2, 2013. <b>(See Attachment E)</b></p> <p>To ensure this deficiency does not occur in the future medication administration will be monitored through monthly and quarterly observation by the Residential</p>				

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	<p>(qualified developmental disabilities professional) before they can pass medications again." LPN #1 indicated client #4 takes the medication Tenex for ADHD, not hypertension.</p> <p>An interview with the QDDP was completed on 1/3/13 at 2:15 P.M. The QDDP stated, "The errors did happen and staff retraining did occur. We also encouraged staff to make sure the environment was calm so they could concentrate."</p> <p>9-3-6(a)</p>		<p>Manager, Nurse, QDP and Residential Coordinator</p> <p><b>Nurse, QDP, Residential Manager and Residential Coordinator Responsible</b></p>		