

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00173081.</p> <p>COMPLAINT #IN00173081: UNSUBSTANTIATED, due to lack of sufficient evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of survey: June 11, 12, 15 and 16, 2015.</p> <p>Facility number: 001050 Provider number: 15G536 AIM number: 100245380</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based upon observation, interview and record review, the governing body failed for 1 of 4 sampled clients (client B), to ensure policy and procedures which prohibited abuse, neglect and exploitation were implemented. The governing body failed to ensure the client was supervised to protect client B from pica (eating inedibles/rubber glove) after a history of pica had been identified, failed to address the practice of staff carrying rubber gloves after the practice was identified as a potential factor in client B ingesting a rubber glove, and failed to develop and implement a monitoring system to ensure gloves were not accessible to client B.</p> <p>Findings include:</p> <p>1. The governing body failed for 1 of 4 sampled clients (client B), to ensure policy and procedures which prohibited abuse, neglect and exploitation were implemented. The governing body failed to ensure the client was supervised to protect client B from pica (eating inedibles/rubber glove) after a history of pica had been identified, failed to address the practice of staff carrying rubber</p>	W 0104	<p>W104</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>The QDPs, Residential Managers, and Coordinators received additional training on 6/29/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. All Direct Support Staff working in the home received training on the procedure for rubber gloves on 6/23/15 (See attachment B). Environment checks of client B's bedroom was implemented on 6/24/15 (See Attachment C). Client B's Self-Management plan was updated on 6/15/15 to reflect eyesight supervision and procedures for glove use and disposal (See Attachment D). All Direct Support Staff working in the home received training on client B's updated Self-Management plan on 6/23/15 (See Attachment E). All Direct Support staff working in the home received training on the Incident/Abuse/Neglect policy on</p>	07/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2015
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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	
	<p>gloves after the practice was identified as a potential factor in client B ingesting a rubber glove, and failed to develop and implement a monitoring system to ensure gloves were not accessible to client B. Please see W149.</p> <p>2. The governing body failed for 1 of 4 sampled clients (client B), to ensure client was supervised to protect client B from pica (eating inedibles/rubber glove) after a history of pica had been identified, failed to address the practice of staff carrying rubber gloves after the practice was identified as a potential factor in client B ingesting a rubber glove, and failed to develop and implement a monitoring system to ensure gloves were not accessible to client B. Please see W157.</p> <p>3. The governing body failed for 1 of 4 sampled clients (client B) to ensure staff were trained to competency to protect client B from ingesting a glove after a history of ingesting gloves had been identified. Please see W191.</p> <p>4. The governing body failed for 1 of 4 sampled clients (client A) to identify specific instructions in the client's ISP (Individual Support Plan) to address client A's physical aggression. Please see W240.</p>		<p>6/23/15 (See Attachment F). Client A's Self-Management plan was updated on 6/15/15 (See Attachment G). All Direct Support staff working in the home received training on Client A's updated Self-Management plan on 6/23/15 (See Attachment H). The QDP received training on ensuring all risk plans have been evaluated and updated as necessary when significant concerns arise on 6/29/15 See Attachment I. All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 7/16/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will review IDTs to ensure that all necessary changes have been made to risk plans once recommendations have been made.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
---	--	---	--

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
--------------------------	--	---------------------	--	----------------------------

	9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (client B). The facility failed for 1 of 4 sampled clients (client B), to ensure policy and procedures which prohibited abuse, neglect and exploitation were implemented. The facility failed to ensure the client was supervised to protect client B from pica (eating inedibles/rubber glove) after a history of pica had been identified, failed to address the practice of staff carrying rubber gloves after the practice was identified as a potential factor in client B ingesting a rubber glove, and failed to develop and implement a monitoring system to ensure gloves were not accessible to client B.</p> <p>Findings include:</p> <p>1. The facility failed for 1 of 4 sampled clients (client B), to ensure policy and procedures which prohibited abuse, neglect and exploitation were implemented. The facility failed to ensure the client was supervised to protect client B from pica (eating inedibles/rubber glove) after a history of pica had been identified, failed to address the practice of staff carrying rubber gloves after the practice was identified as a potential factor in client B ingesting a rubber</p>	W 0122	<p>W122</p> <p>The Facility must ensure that specific client protections requirements are met.</p> <p>The QDPs, Residential Managers, and Coordinators received additional training on 6/29/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. All Direct Support staff working in the home received training on the Incident/Abuse/Neglect policy on 6/23/15 (See Attachment F). Environment checks of client B's bedroom was implemented on 6/24/15 (See Attachment C). Client B's Self-Management plan was updated on 6/15/15 to reflect eyesight supervision and procedures for glove use and disposal (See Attachment D). All Direct Support Staff working in the home received training on client B's updated Self-Management plan on 6/23/15 (See Attachment E). All Direct Support Staff working in the home received training on the procedure for rubber gloves on 6/23/15 (See Attachment B). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 7/16/15.</p>	07/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2015
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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	
	<p>glove, and failed to develop and implement a monitoring system to ensure gloves were not accessible to client B. Please see W149.</p> <p>2. The facility failed for 1 of 4 sampled clients (client B), to ensure the client was supervised to protect client B from pica (eating inedibles/rubber glove) after a history of pica had been identified, failed to address the practice of staff carrying rubber gloves after the practice was identified as a potential factor in client B ingesting a rubber glove, and failed to develop and implement a monitoring system to ensure gloves were not accessible to client B. Please see W157.</p> <p>9-3-2(a)</p>		<p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2015
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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	
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based upon observation, interview and record review, the facility failed for 1 of 4 sampled clients (client B), to ensure policy and procedures which prohibited abuse, neglect and exploitation were implemented. The facility failed to ensure the client was supervised to protect client B from pica (eating inedibles/rubber glove) after a history of pica had been identified, failed to address the practice of staff carrying rubber gloves after the practice was identified as a potential factor in client B ingesting a rubber glove, and failed to develop and implement a monitoring system to ensure gloves were not accessible to client B.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations were reviewed on 6/11/15 at 4:55 PM and indicated the following:</p> <p>1. A BDDS report dated 6/4/15 indicated client B had an upper endoscopy "with removal of foreign object" under general anesthesia during the procedure. "The object was removed successfully and</p>	W 0149	<p>W149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client. The QDPs, Residential Managers, and Coordinators received additional training on 6/29/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans.</p> <p>Client B's Self-Management plan was updated on 6/15/15 to reflect eyesight supervision and procedures for glove use and disposal (See Attachment D). All Direct Support Staff working in the home received training on client B's updated Self-Management plan on 6/23/15 (See Attachment E). All Direct Support Staff working in the home received training on the procedure for rubber gloves on 6/23/15 (See attachment B). Environment checks of client B's bedroom was implemented on 6/24/15 (See Attachment C). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 7/16/15. To ensure this deficiency does not occur again, the Residential Manager, DSP 2</p>	07/16/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2015	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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			
	<p>[client B] was sent home with instructions to return to doctor as needed." Corrective action indicated "staff will continue to support [client B] and observe him for any adverse side effects. Staff will contact Residential Manager (RM) and Nurse if any occur." A follow up report dated 6/5/15 indicated the item removed from client B during the endoscopy was a rubber glove. "Staff will continue to monitor [client B] and report any concerns to the RM and the Residential Nurse immediately."</p> <p>An investigation dated 5/12/15 into the incident on 5/11/15 was reviewed on 6/12/15 at 4:00 PM and indicated client B had a scheduled colonoscopy due to weight loss. "He had lost approximately 10 lbs (pounds) throughout the year. During the procedure a rubber glove was found in the Gastric body. Dr. [name] stated that there were no immediate complications and scheduled a consultation on 5/12/15 to discuss the removal of the glove." The investigation indicated client B's doctor "stated he was not concerned with the glove being there as it was not causing any negative effects." Staff #1 indicated she had not seen client B "mouthing anything" or with any gloves. Staff #1 indicated she "does sometimes place gloves in her pocket to assist with showers and other</p>		and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>hygiene needs in the mornings." Staff #13 indicated she did not observe client B with gloves and "stated that she does carry gloves in her back pocket so if she needs them she can access them quickly." The RM indicated she had observed "staff carrying gloves in their pockets for easy access. I have never observed staff dropping gloves or disposing of them any places that are not approved...." Staff #12, #7 and #10 indicated in their statements they did not carry gloves in their pockets and all staff indicated they disposed of gloves either in the trash located in the medication closet or in the laundry area. The conclusion of the investigation indicated "an exact date and time as to when [client B] ingested the foreign body could not be determined...At times staff has been observed putting gloves in their pockets so they have them to assist individuals with their hygiene needs. The most logical explanation for [client B] obtaining the glove is that staff had placed gloves in their pockets and possibly dropped one on accident without realizing it. This is the most probable cause for how [client B] could have obtained the glove as gloves are only to be disposed of in the med (medication) closet and the trash can beside the washer as they are not easily accessible. Gloves are stored in the restroom in a twist top</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>container which [client B] cannot open on his own and in the storage closet and the med closet. [Client B] does have a history of PICA and he tends to mouth items and has attempted to eat items that are not edible this (sic) is addressed in his self-management plan. Staff redirects him when he is observed having items that he should not have." Outcome of the investigation indicated "The IDT (interdisciplinary team) met and agreed that it is in the best interest of [client B] to be within eyesight at all times to ensure this type of incident does not occur again...." The investigation did not address staff's practice of carrying gloves and its potential for providing access to gloves for client B in the future.</p> <p>Client B's records were reviewed on 6/11/15 at 5:28 PM. An ISP (Individual Support Plan) dated 1/7/15 indicated client B required 24 hour supervision and support, and "I need support in managing my maladaptive behaviors, which include: PICA (rubber gloves and paper), water obsessions, leaning/pushing staff and personal space issues." Intervention Strategies (IS) dated 1/7/15 for PICA indicated client B liked to tear up magazines and place them in his mouth. "I am also skillful at hiding non-edible items and then ingesting them when unsupervised, like when I am in bed...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>The IS indicated client B had a colonoscopy in February, 2006 to remove 2 ingested latex gloves, and had one undated incident of ingesting Epsom salt mixture and in October, 2007 had an incident in which client B placed his fingers in non-toxic paint and then brought his fingers to his mouth. The strategy indicated "Rubber gloves will be kept in a box that is out of reach for me. Rubber gloves will only be thrown away in one central place...Staff should monitor me careful (sic) when I am close to plastic or paper." The plan indicated staff were to redirect client B to another activity if he placed something inedible into his mouth, and staff were to monitor client B "VERY closely" around paint or liquid mixtures. There was no description or definition of staff monitoring required for client B to prevent access to gloves or inedible objects/liquids in the 1/7/15 plan.</p> <p>The record included an IDT note dated 5/19/15 which indicated "It is stated in his (client B) self management strategies to dispose of gloves in 2 places. Staff have tried putting signs on the trash cans indicating that there should only be gloves in the 2 trash cans and the RM still continues to find them in other trash cans." The note indicated client B has been "constantly taking his shirt off and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>scratching himself...Due to these issues the IDT is recommending that [client B] be within eyesight to help decrease risk of PICA and scratches." The note indicated client B would visit another group home "to see how he would fit in there. He would be more around peers of his capability and also staff there are vigilant about PICA issues...." The note indicated client B's guardian had approved the visit.</p> <p>House Meeting Training dated 5/26/15 was reviewed on 6/11/15 at 5:58 PM. The issues discussed included "recent IDTs," and included training for, but not limited to staff #7, #10, #12, #14, #9, #2, #4 and #6. Which clients' IDTs included in the training were not identified in the documentation.</p> <p>Observations were completed at the group home on 6/11/15 from 6:00 PM until 6:45 PM. Client B got on the floor and attempted to pick up food crumbs before being redirected by staff #10 during the observation.</p> <p>The Residential Coordinator (RC) indicated via email dated 6/12/15 at 3:39 PM, "The RC spoke with the RM regarding training staff on not carrying the gloves in their pockets. She stated that she did not train staff to not carry the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
--------------------	--	---------------	---	----------------------

	<p>gloves in their pocket as the IDT implemented [client B] being within eyesight. It was felt that with [client B] being in eyesight at all times staff would visibly see if he had something that he should not have. The IDT discussed various options to maintain his safety. Eye site (sic) supervision was deemed the best and most appropriate action to be taken."</p> <p>Staff training records were reviewed on 6/16/15 at 7:35 AM and indicated staff #1, #13, #4, #14, #10 and #7 were trained on client B's ISP and risk plans on 1/8/15. Staff #12 was trained on client B's plan on 8/23/14.</p> <p>The Adult Services Director (ASD) was interviewed on 6/15/15 at 4:32 PM. When asked if client B's supervision was a factor in his access to gloves, she stated, "We can't confirm it. That's why the plan is being revised to prevent that (access to gloves and inedibles)." The ASD indicated client B's plan would be reviewed with the QDP to determine if staff had followed his previous plan. The ASD indicated there was not a formal monitoring system in place to determine if staff were correctly disposing of gloves and with client B now being within eyesight supervision, staff should be able to intervene prior to client B obtaining</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>items that were inedible.</p> <p>Client B's Intervention Strategies (IS) dated 1/7/15, updated 5/19/15 and on 6/15/15 was provided via e-mail on 6/16/15 at 8:59 AM and reviewed on 6/16/15 at 9:20 AM. The IS indicated revisions of "Rubber gloves will be only be thrown away in 2 central locations both of which are in secure areas not easily accessed by persons served. One location is in a locked med closet. The other location is in the laundry room where I rarely go. The trash can will always have a lid. All trash cans within the home will have lids that seal and have to be opened with a pedal." The intervention strategy failed to define client B was to be within eyesight supervision at all times.</p> <p>The Support Services Coordinator (SSC) was interviewed on 6/16/15 at 10:26 AM and indicated she would check with the QDP to ensure the plan provided was the most updated IS.</p> <p>The SSC emailed an updated IS for client B on 6/16/15 at 10:48 AM. The plan indicated it had been updated on 5/19/15 and on 6/15/15 and indicated a statement "Due to having recent issues with ingesting gloves I need to be within eyesight of staff when I am awake."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>The SSC was interviewed on 6/16/15 at 10:44 AM and indicated the IS provided to the surveyor was missing the statement regarding eyesight supervision as it had been inadvertently deleted from client B's updated plan. She indicated the staff training on 5/26/15 included the updated plan for client B regarding pica.</p> <p>The QDP was interviewed on 6/16/15 at 12:40 PM and indicated client B's plan to address pica dated 1/7/15 indicated he was to be closely monitored.</p> <p>The facility's policy and procedures "Cardinal Services, Inc. Incident/Abuse/Neglect Policy Persons Served dated 5/13 was reviewed on 6/15/15 at 2:22 PM and indicated in part, "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...." Neglect was defined as "Incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his or her life or health...)." </p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
--------------------	--	---------------	---	----------------------

W 0157 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based upon observation, interview and record review, the facility failed for 1 of 4 sampled clients (client B), to ensure the client was supervised to protect client B from pica (eating inedibles/rubber glove) after a history of pica had been identified, failed to address the practice of staff carrying rubber gloves after the practice was identified as a potential factor in client B ingesting a rubber glove, and failed to develop and implement a monitoring system to ensure gloves were not accessible to client B.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations were reviewed on 6/11/15 at 4:55 PM and indicated the following:</p> <p>A BDDS report dated 6/4/15 indicated client B had an upper endoscopy "with removal of foreign object" under general anesthesia during the procedure. "The object was removed successfully and [client B] was sent home with</p>	W 0157	<p>W157</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>The QDPs, Residential Managers, and Coordinators received additional training on 6/29/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. All Direct Support Staff working in the home received training on client B's updated Self-Management plan on 6/23/15 (See Attachment E). All Direct Support Staff working in the home received training on the procedure for rubber gloves on 6/23/15 (See Attachment B). Environment checks of client B's bedroom was implemented on 6/24/15 (See Attachment C). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 7/16/15.</p> <p>To ensure this deficiency does not occur again, the Residential</p>	07/16/2015
--------------------	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2015
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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	
	<p>instructions to return to doctor as needed." Corrective action indicated "staff will continue to support [client B] and observe him for any adverse side effects. Staff will contact Residential Manager (RM) and Nurse if any occur." A follow up report dated 6/5/15 indicated the item removed from client B during the endoscopy was a rubber glove. "Staff will continue to monitor [client B] and report any concerns to the RM and the Residential Nurse immediately."</p> <p>An investigation dated 5/12/15 into the incident on 5/11/15 was reviewed on 6/12/15 at 4:00 PM and indicated client B had a scheduled colonoscopy due to weight loss. During the procedure a rubber glove was found in the Gastric body. Dr. [name] stated that there were no immediate complications and scheduled a consultation on 5/12/15 to discuss the removal of the glove." The investigation indicated client B's doctor "stated he was not concerned with the glove being there as it was not causing any negative effects." Staff #1 indicated she had not seen client B "mouthing anything" or with any gloves. Staff #1 indicated she "does sometimes place gloves in her pocket to assist with showers and other hygiene needs in the mornings." Staff #13 indicated she did not observe client B with gloves and</p>		<p>Manager, DSP 2 and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	"stated that she does carry gloves in her back pocket so if she needs them she can access them quickly." The RM indicated she had observed "staff carrying gloves in their pockets for easy access. I have never observed staff dropping gloves or disposing of them any places that are not approved..." Staff #12, #7 and #10 indicated in their statements they did not carry gloves in their pockets and all staff indicated they disposed of gloves either in the trash located in the medication closet or in the laundry area. The conclusion of the investigation indicated "an exact date and time as to when [client B] ingested the foreign body could not be determined...At times staff has been observed putting gloves in their pockets so they have them to assist individuals with their hygiene needs. The most logical explanation for [client B] obtaining the glove is that staff had placed gloves in their pockets and possibly dropped one on accident without realizing it. This is the most probable cause for how [client B] could have obtained the glove as gloves are only to be disposed of in the med (medication) closet and the trash can beside the washer as they are not easily accessible. Gloves are stored in the restroom in a twist top container which [client B] cannot open on his own and in the storage closet and the med closet. [Client B] does have a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>history of PICA and he tends to mouth items and has attempted to eat items that are not edible this (sic) is addressed in his self-management plan. Staff redirects him when he is observed having items that he should not have." Outcome of the investigation indicated "The IDT (interdisciplinary team) met and agreed that it is in the best interest of [client B] to be within eyesight at all times to ensure this type of incident does not occur again...." The investigation did not address staff's practice of carrying gloves and its potential for providing access to gloves for client B in the future.</p> <p>Client B's records were reviewed on 6/11/15 at 5:28 PM. An ISP (Individual Support Plan) dated 1/7/15 indicated client B required 24 hour supervision and support, and "I need support in managing my maladaptive behaviors, which include: PICA (rubber gloves and paper), water obsessions, leaning/pushing staff and personal space issues." Intervention Strategies (IS) dated 1/7/15 for PICA indicated client B liked to tear up magazines and place them in his mouth. "I am also skillful at hiding non-edible items and then ingesting them when unsupervised, like when I am in bed...." The IS indicated client B had a colonoscopy in February, 2006 to remove 2 ingested latex gloves, and had one</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>undated incident of ingesting Epsom salt mixture and in October, 2007 had an incident in which client B placed his fingers in non-toxic paint and then brought his fingers to his mouth. The strategy indicated "Rubber gloves will be kept in a box that is out of reach for me. Rubber gloves will only be thrown away in one central place...Staff should monitor me careful (sic) when I am close to plastic or paper." The plan indicated staff were to redirect client B to another activity if he placed something inedible into his mouth, and staff were to monitor client B "VERY closely" around paint or liquid mixtures. There was no description or definition of staff monitoring required for client B to prevent access to gloves or inedible objects/liquids in the 1/7/15 plan.</p> <p>The record included an IDT note dated 5/19/15 which indicated "It is stated in his (client B) self management strategies to dispose of gloves in 2 places. Staff have tried putting signs on the trash cans indicating that there should only be gloves in the 2 trash cans and the RM still continues to find them in other trash cans." The note indicated client B has been "constantly taking his shirt off and scratching himself...Due to these issues the IDT is recommending that [client B] be within eyesight to help decrease risk</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>of PICA and scratches."</p> <p>House Meeting Training dated 5/26/15 was reviewed on 6/11/15 at 5:58 PM. The issues discussed included "recent IDTs," and included training for, but not limited to staff #7, #10, #12, #14, #9, #2, #4 and #6. The IDTs were not identified in the documentation.</p> <p>Observations were completed at the group home on 6/11/15 from 6:00 PM until 6:45 PM. Client B got on the floor and attempted to pick up food crumbs before being redirected by staff #10 during the observation. Client B was within arms length of the staff at all times during the observation. The home had two trash cans in the kitchen areas with swinging lids labeled "No gloves."</p> <p>The Residential Coordinator (RC) indicated via email dated 6/12/15 at 3:39 PM, "The RC spoke with the RM regarding training staff on not carrying the gloves in their pockets. She stated that she did not train staff to not carry the gloves in their pocket as the IDT implemented [client B] being within eyesight. It was felt that with [client B] being in eyesight at all times staff would visibly see if he had something that he should not have. The IDT discussed various options to maintain his safety.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>Eye site (sic) supervision was deemed the best and most appropriate action to be taken."</p> <p>The Adult Services Director (ASD) was interviewed on 6/15/15 at 4:32 PM. When asked if client B's supervision was a factor in his access to gloves, she stated, "We can't confirm it. That's why the plan is being revised to prevent that (access to gloves and inedibles)." The ASD indicated client B's plan would be reviewed with the QDP to determine if staff had followed his previous plan. The ASD indicated there was not a formal monitoring system in place to determine if staff were correctly disposing of gloves and with client B now being within eyesight supervision, staff should be able to intervene prior to client B obtaining items that were inedible.</p> <p>Client B's Intervention Strategies (IS) dated 1/7/15, updated 5/19/15 and on 6/15/15 was provided via e-mail on 6/16/15 at 8:59 AM was reviewed on 6/16/15 at 9:20 AM. The IS indicated revisions of "Rubber gloves will be only be thrown away in 2 central locations both of which are in secure areas not easily accessed by persons served. One location is in a locked med closet. The other location is in the laundry room where I rarely go. The trash can will</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>always have a lid. All trash cans within the home will have lids that seal and have to be opened with a pedal." The intervention strategy failed to define client B was to be within eyesight supervision at all times.</p> <p>The Support Services Coordinator (SSC) was interviewed on 6/16/15 at 10:26 AM and indicated she would check with the QDP to ensure the plan provided was the most updated IS.</p> <p>The SSC emailed an updated IS for client B on 6/16/15 at 10:48 AM. The plan indicated it had been updated on 5/19/15 and on 6/15/15 and indicated a statement "Due to having recent issues with ingesting gloves I need to be within eyesight of staff when I am awake."</p> <p>The SSC was interviewed on 6/16/15 at 10:44 AM and indicated the IS provided to the surveyor was missing the statement regarding eyesight supervision as it had been inadvertently deleted from client B's updated plan. She indicated the staff training on 5/26/15 included the updated plan for client B regarding pica.</p> <p>The QDP was interviewed on 6/16/15 at 12:40 PM and indicated client B's plan to address pica dated 1/7/15 indicated he was to be closely monitored.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
---	--	---	--

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	9-3-2(a)			
W 0191 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. Based on observation, record review and interview for 1 of 4 sampled clients (client B), the facility failed to ensure staff were trained to competency to protect client B from ingesting a glove after a history of ingesting gloves had	W 0191	W191 For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.	07/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2015
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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	
	<p>been identified.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations were reviewed on 6/11/15 at 4:55 PM and indicated the following:</p> <p>A BDDS report dated 6/4/15 indicated client B had an upper endoscopy "with removal of foreign object" under general anesthesia during the procedure. "The object was removed successfully and [client B] was sent home with instructions to return to doctor as needed." Corrective action indicated "staff will continue to support [client B] and observe him for any adverse side effects. Staff will contact Residential Manager (RM) and Nurse if any occur." A follow up report dated 6/5/15 indicated the item removed from client B during the endoscopy was a rubber glove. "Staff will continue to monitor [client B] and report any concerns to the RM and the Residential Nurse immediately."</p> <p>An investigation dated 5/12/15 into the incident on 5/11/15 was reviewed on 6/12/15 at 4:00 PM and indicated client B had a scheduled colonoscopy due to weight loss. "He had lost approximately</p>		<p>All Direct Support Staff working in the home received training on client B's updated Self-Management plan on 6/23/15 (See Attachment E). All Direct Support Staff working in the home received training on the procedure for rubber gloves on 6/23/15 (See attachment B). The QDPs, Residential Managers, and Coordinators received additional training on 6/29/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 7/16/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>10 lbs (pounds) throughout the year. During the procedure a rubber glove was found in the Gastric body. Staff #1 indicated she had not seen client B "mouthing anything" or with any gloves. Staff #1 indicated she "does sometimes place gloves in her pocket to assist with showers and other hygiene needs in the mornings." Staff #13 indicated she did not observe client B with gloves and "stated that she does carry gloves in her back pocket so if she needs them she can access them quickly." The RM indicated she had observed "staff carrying gloves in their pockets for easy access. I have never observed staff dropping gloves or disposing of them any places that are not approved...." Staff #12, #7 and #10 indicated in their statements they did not carry gloves in their pockets and all staff indicated they disposed of gloves either in the trash located in the medication closet or in the laundry area. The conclusion of the investigation indicated "an exact date and time as to when [client B] ingested the foreign body could not be determined...At times staff has been observed putting gloves in their pockets so they have them to assist individuals with their hygiene needs. The most logical explanation for [client B] obtaining the glove is that staff had placed gloves in their pockets and possibly dropped one on accident without</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>realizing it. This is the most probable cause for how [client B] could have obtained the glove as gloves are only to be disposed of in the med (medication) closet and the trash can beside the washer as they are not easily accessible. Gloves are stored in the restroom in a twist top container which [client B] cannot open on his own and in the storage closet and the med closet. [Client B] does have a history of PICA and he tends to mouth items and has attempted to eat items that are not edible this (sic) is addressed in his self-management plan. Staff redirects him when he is observed having items that he should not have." Outcome of the investigation indicated "The IDT (interdisciplinary team) met and agreed that it is in the best interest of [client B] to be within eyesight at all times to ensure this type of incident does not occur again...."</p> <p>Client B's records were reviewed on 6/11/15 at 5:28 PM. An ISP (Individual Support Plan) dated 1/7/15 indicated client B required 24 hour supervision and support, and "I need support in managing my maladaptive behaviors, which include: PICA (rubber gloves and paper), water obsessions, leaning/pushing staff and personal space issues." Intervention Strategies (IS) dated 1/7/15 for PICA indicated client B liked to tear up</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>magazines and place the pieces of paper in his mouth. "I am also skillful at hiding non-edible items and then ingesting them when unsupervised, like when I am in bed..." The IS indicated client B had a colonoscopy in February, 2006 to remove 2 ingested latex gloves, and had one undated incident of ingesting Epsom salt mixture and in October, 2007 had an incident in which client B placed his fingers in non-toxic paint and then brought his fingers to his mouth. The strategy indicated "Rubber gloves will be kept in a box that is out of reach for me. Rubber gloves will only be thrown away in one central place...Staff should monitor me careful (sic) when I am close to plastic or paper." The plan indicated staff were to redirect client B to another activity if he placed something inedible into his mouth, and staff were to monitor client B "VERY closely" around paint or liquid mixtures.</p> <p>The record included an IDT note dated 5/19/15 which indicated "It is stated in his (client B) self management strategies to dispose of gloves in 2 places. Staff have tried putting signs on the trash cans indicating that there should only be gloves in the 2 trash cans and the RM still continues to find them in other trash cans." The note indicated client B has been "constantly taking his shirt off and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>scratching himself...Due to these issues the IDT is recommending that [client B] be within eyesight to help decrease risk of PICA and scratches." The note indicated client B would visit another group home "to see how he would fit in there. He would be more around peers of his capability and also staff there are vigilant about PICA issues...." The note indicated client B's guardian had approved the visit.</p> <p>House Meeting Training dated 5/26/15 was reviewed on 6/11/15 at 5:58 PM. The issues discussed included "recent IDTs," and included training for, but not limited to staff #7, #10, #12, #14, #9, #2, #4 and #6.</p> <p>Observations were completed at the group home on 6/11/15 from 6:00 PM until 6:45 PM. Client B got on the floor and attempted to pick up food crumbs before being redirected by staff #10 during the observation.</p> <p>Staff training records were reviewed on 6/16/15 at 7:35 AM and indicated staff #1, #13, #4, #14, #10 and #7 were trained on client B's ISP and risk plans on 1/8/15. Staff #12 was trained on client B's plan on 8/23/14.</p> <p>The Adult Services Director was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>interviewed on 6/15/15 at 4:32 PM. When asked if client B's supervision was a factor in his access to gloves, she stated, "We can't confirm it. That's why the plan is being revised to prevent that (access to gloves and inedibles)."</p> <p>Client B's Intervention Strategies (IS) dated 1/7/15, updated 5/19/15 and on 6/15/15 was provided via e-mail on 6/16/15 at 8:59 AM was reviewed on 6/16/15 at 9:20 AM. The IS indicated revisions of "Rubber gloves will be only be thrown away in 2 central locations both of which are in secure areas not easily accessed by persons served. One location is in a locked med closet. The other location is in the laundry room where I rarely go. The trash can will always have a lid. All trash cans within the home will have lids that seal and have to be opened with a pedal." The intervention strategy failed to define client B was to be within eyesight supervision at all times.</p> <p>The Support Services Coordinator (SSC) was interviewed on 6/16/15 at 10:26 AM and indicated she would check with the QDP to ensure the plan provided was the most updated IS.</p> <p>The SSC emailed an updated IS for client B on 6/16/15 at 10:48 AM. The plan</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>indicated it had been updated on 5/19/15 and on 6/15/15 and indicated a statement "Due to having recent issues with ingesting gloves I need to be within eyesight of staff when I am awake."</p> <p>The SSC was interviewed on 6/16/15 at 10:44 AM and indicated the IS provided to the surveyor was missing the statement regarding eyesight supervision as it had been inadvertently deleted from client B's updated plan. She indicated the staff training on 5/26/15 included the updated plan for client B regarding pica.</p> <p>The QDP was interviewed on 6/16/15 at 12:40 PM and indicated client B's plan to address pica dated 1/7/15 indicated he was to be closely monitored.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2015	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
W 0240 Bldg. 00	<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 1 of 4 sampled clients (client A), the facility failed to identify specific instructions in the client's ISP (Individual Support Plan) to address physical aggression.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/11/15 at 4:55 PM.</p> <p>1. A BDDS report dated 5/1/15 indicated client A "was going after staff and peer with her fist, staff redirected [client A] at this time. [Client A] threw herself back towards staff and staff gently lowered her to the ground for her safety. [Client A] was yelling and cussing at staff as she was kicking at staff in the legs and groin area. For the safety of [client A] and those around her she was placed in a Cardinal Services approved hold. 911 was called due to staff inability to get [client A] to calm down and not injure those around her. [Client A] was in the support hold for approximately 1 and 1/2-2 minutes when she calmed down and the officers arrived. Once the officers walked in, [client A] began scratching at kicking at staff again at which point the officer held her wrists and knee cap for approximately 2 minutes...[Client A] calmed down and the officer released his hold. [Client A] received a nickel sized abrasion on her left elbow area and a quarter size abrasion on her right elbow from throwing</p>			W 0240	<p>W240</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Client A's Self-Management plan was updated on 6/15/15 to reflect intervention strategies during incidents of physical aggression (See Attachment G). All Direct Support staff working in the home received training on Client A's updated Self-Management plan on 6/23/15 (See Attachment H). The QDP received training on ensuring all risk plans have been evaluated and updated as necessary when significant concerns arise on 6/29/15 (See Attachment I). The QDPs, Residential Managers, and Coordinators received additional training on 6/29/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 7/16/15.</p>		07/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>herself backwards onto staff and being lowered to the floor. [Client A] did not observe any injuries (sic) from the support hold that was utilized." Corrective action indicated "Staff will continue to follow [client A's] Self-Management plan and consult with the QDP (Qualified Disabilities Professional) regarding these concerns." A follow up report dated 5/5/15 indicated the support hold utilized was not in client A's plan. Client A's "IDT (Interdisciplinary Team) met to discuss [client A's] aggression and potential cause. The IDT feels that [client A] is getting frustrated with staff having to walk within arm's reach of her and she is becoming angry. The IDT agreed that it would be in [client A's] best interest to have a new PT (physical therapy) evaluation to see if she had changes in her ambulation. Staff will encourage [client A] to utilize her cane more frequently and based upon PT recommendations it is possible that [client A] will not need to be within arm's reach while she is walking unless she is not feeling well or displaying signs of unsteady gait..." A follow up report dated 5/6/15 indicated the support hold was not implemented prior to least restrictive interventions being implemented first and the attempts being unsuccessful...The QDP will be contacting [client A's] counselor to make them aware of the struggles [client A] has been experiencing and to request the counselor work with [client A] on coping skills. The IDT further agreed that staff will be retrained on [client A's] self management plan and to release training pressures when she is becoming upset and utilized planned ignore while keeping her within eyesight for her safety and the safety of those around her...."</p> <p>IDT notes dated 5/4/15 attached to the BDDS report indicated "The IDT met regarding [client A]. She has been having more episodes of physical aggression towards others. It got to the</p>		<p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will review IDTs to ensure that all necessary changes have been made to risk plans once recommendations have been made.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>point where staff called the cops to assist on 5/1/15. The IDT feels that [client A] feels suffocated from staff assisting her at all times with ambulating. She wants to do this on her own. She has not had a fall in awhile...When [client A] does have a behavior staff should back off and make sure the area is clear of objects that she could hurt herself with. First priority is to get other persons served away from the situation. Staff will ignore her until she calms down. IDT will meet again if problems continue." The notes did not indicate if restraints or calling the police were considered in the IDT discussion.</p> <p>An investigation into the incident dated 5/4/15 indicated a conclusion client A had become "upset because she did not want [client B] to sit in the lift chair...When staff attempted to remind her that is was no (sic) her chair it belonged to everyone living in the home she grew even more upset..." Outcome of investigation indicated Client A would be scheduled for a PT evaluation to determine if it was possible to allow her to walk without staff assistance. Staff is to "encourage clients [A and B] to stay on the opposite side of the home to prevent further issues and monitor the two when they are in the same area. Staff will provide [client A] with space when she is upset to allow her time to calm down and will remove her peers from the area."</p> <p>Client A's records were reviewed on 6/11/15 at 6:35 PM. An IDT note dated 6/3/15 indicated client A had been evaluated that day by PT and "the therapist did say that a walker would be the most effective way to prevent falls. We discussed the use of a cane. The therapist had [client A] walk both with and without a cane and feels that it would be best if [client A] does not use a cane at this time." The note indicated staff would need to walk with client A on her left side, and the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>therapist indicated to client A that if she did not want staff to assist her with the use of a gait belt, she would need to walk at a slow pace. Client A would utilize a gait belt in the community if she became unsteady. The note indicated client A agreed to the measures and her plan would be updated. There was no evidence the IDT discussed the use of restraints or the calling the police to address physical aggression.</p> <p>Client A's Self Management Plan dated 1/14/15 indicated client A had lived alone for 1 and 1/2 years in an apartment prior to moving back to her relative's home and had moved into the group home on 1/24/13. The plan indicated target behaviors of physical aggression, verbal aggression and depressive symptoms (tearfulness, withdrawal, and not doing activities...). Proactive interventions for physical aggression indicated "encourage me to make decisions for myself and give me options of things to do, give me time to do things and don't rush me." Reactive interventions indicated "If I am physically aggressive towards someone, staff should immediately ask me to 'stop.' If it is staff I am targeting, another staff should step in to assist me allowing the targeted staff to exit the area. If I am targeting a peer, staff should immediately assist the peer to safety. First try redirecting me to my room with verbal prompts and back off training pressure if it is while doing a task. If I will not leave the area redirect peers to a different area...." The plan did not include the use of physical restraint or of calling the police.</p> <p>The QDP/QIDP (Qualified Disabilities Professional)/(Qualified Intellectual Disabilities Professional) was interviewed on 6/11/15 at 5:15 PM and indicated client A's self management plan had not been changed, but alterations to her plan</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>regarding staff assistance in walking had been implemented to address client A's frustration.</p> <p>The Residential Coordinator (RC) was interviewed on 6/11/15 at 5:45 PM and when asked why the police were called after client A was restrained for 1/12-2 minutes, stated, "They could not calm her down. They were fearful of clients' safety and the police were called." The RC indicated client A became aggressive again after police arrived.</p> <p>The Residential Manager (RM) was interviewed on 6/11/15 at 6:20 PM and indicated client A became upset because she thought client B was sitting in a chair that was hers. The RM indicated client A's plan was reviewed and revised as it was not specific regarding what to do if the interventions of telling her to stop and clearing the area were not effective. The RM stated, "Staff could have handled it better," but had implemented client A's self management plan prior to using the restraint and calling police. She stated, staff "needed more (interventions)-this was a new behavior." The RM indicated the IDT considered other options and stated, the use of the gait belt was "a source of frustration-she just needed space." The RM indicated during client A's PT evaluation, the therapist stated "the use of the walker for client A was still best, but if she wants to use the cane it would still work as her legs are strong." The RM indicated when she talked to client A about the use of the walker, client A indicated the walker was of limited assistance to her as client A was unable to apply the brakes due to limited use of her hands as a result of her diagnosis of CP (cerebral palsy). The RM indicated the incident of physical aggression displayed by client A on 5/11/15 was a new behavior. The RM stated upon reviewing client A's history of living on her own, "We should be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>encouraging her to do more," and indicated client A had been performing more tasks independently since the incident and had displayed less frustration.</p> <p>The RC indicated via email dated 6/12/15 at 3:39 PM, "staff was verbally told by the QDP not to call the police during their house meeting, however, this was a verbal request and it is not documented. The QDP is updating [client A's] Self-Management plan to reflect intervention strategies from least restrictive to most restrictive. This will include verbal redirection, approved support hold if necessary and then notifying the police department for assistance if the situation becomes too severe and staff are not able to provide for [client A's] safety or those around her."</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client B) to ensure staff implemented client B's plan to prevent the ingestion of gloves.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations were reviewed on 6/11/15 at 4:55 PM and indicated the following:</p> <p>A BDDS report dated 6/4/15 indicated client was had an upper endoscopy "with removal of foreign object" under general anesthesia during the procedure. "The object was removed successfully and [client B] was sent home with instructions to return to doctor as needed." Corrective action indicated "staff will continue to support [client B]</p>	W 0249	<p>W249</p> <p>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.</p> <p>All Direct Support Staff working in the home received training on client B's updated Self-Management plan on 6/23/15 (See Attachment E). All Direct Support Staff working in the home received training on the procedure for rubber gloves on 6/23/15 (See Attachment B). The QDPs, Residential Managers, and Coordinators received additional training on 6/29/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and</p>	07/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>and observe him for any adverse side effects. Staff will contact Residential Manager (RM) and Nurse if any occur." A follow up report dated 6/5/15 indicated the item removed from client B during the endoscopy was a rubber glove. "Staff will continue to monitor [client B] and report any concerns to the RM and the Residential Nurse immediately."</p> <p>An investigation dated 5/12/15 into the incident on 5/11/15 was reviewed on 6/12/15 at 4:00 PM and indicated client B had a scheduled colonoscopy due to weight loss. Staff #1 indicated she had not seen client B "mouthing anything" or with any gloves. Staff #1 indicated she "does sometimes place gloves in her pocket to assist with showers and other hygiene needs in the mornings." Staff #13 indicated she did not observe client B with gloves and "stated that she does carry gloves in her back pocket so if she needs them she can access them quickly." The RM indicated she had observed "staff carrying gloves in their pockets for easy access. I have never observed staff dropping gloves or disposing of them any places that are not approved...." Staff #12, #7 and #10 indicated in their statements they did not carry gloves in their pockets and all staff indicated they disposed of gloves either in the trash located in the medication closet or in the</p>		<p>implementation of all persons served plans. All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 7/16/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	laundry area. The conclusion of the investigation indicated "an exact date and time as to when [client B] ingested the foreign body could not be determined...At times staff has been observed putting gloves in their pockets so they have them to assist individuals with their hygiene needs. The most logical explanation for [client B] obtaining the glove is that staff had placed gloves in their pockets and possibly dropped one on accident without realizing it. This is the most probable cause for how [client B] could have obtained the glove as gloves are only to be disposed of in the med (medication) closet and the trash can beside the washer as they are not easily accessible. Gloves are stored in the restroom in a twist top container which [client B] cannot open on his own and in the storage closet and the med closet. [Client B] does have a history of PICA and he tends to mouth items and has attempted to eat items that are not edible this (sic) is addressed in his self-management plan. Staff redirects him when he is observed having items that he should not have." Outcome of the investigation indicated "The IDT (interdisciplinary team) met and agreed that it is in the best interest of [client B] to be within eyesight at all times to ensure this type of incident does not occur again...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>Client B's records were reviewed on 6/11/15 at 5:28 PM. An ISP (Individual Support Plan) dated 1/7/15 indicated client B required 24 hour supervision and support, and "I need support in managing my maladaptive behaviors, which include: PICA (rubber gloves and paper), water obsessions, leaning/pushing staff and personal space issues." Intervention Strategies (IS) dated 1/7/15 for PICA indicated client B liked to tear up magazines and place them in his mouth. "I am also skillful at hiding non-edible items and then ingesting them when unsupervised, like when I am in bed...." The IS indicated client B had a colonoscopy in February, 2006 to remove 2 ingested latex gloves, and had one undated incident of ingesting Epsom salt mixture and in October, 2007 had an incident in which client B placed his fingers in non-toxic paint and then brought his fingers to his mouth. The strategy indicated "Rubber gloves will be kept in a box that is out of reach for me. Rubber gloves will only be thrown away in one central place...Staff should monitor me careful (sic) when I am close to plastic or paper." The plan indicated staff were to redirect client B to another activity if he placed something inedible into his mouth, and staff were to monitor client B "VERY closely" around paint or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	<p>liquid mixtures.</p> <p>The record included an IDT note dated 5/19/15 which indicated "It is stated in his (client B) self management strategies to dispose of gloves in 2 places. Staff have tried putting signs on the trash cans indicating that there should only be gloves in the 2 trash cans and the RM still continues to find them in other trash cans." The note indicated client B has been "constantly taking his shirt off and scratching himself...Due to these issues the IDT is recommending that [client B] be within eyesight to help decrease risk of PICA and scratches."</p> <p>Observations were completed at the group home on 6/11/15 from 6:00 PM until 6:45 PM. Client B got on the floor and attempted to pick up food crumbs before being redirected by staff #10 during the observation.</p> <p>The Adult Services Director was interviewed on 6/15/15 at 4:32 PM. When asked if client B's supervision was a factor in his access to gloves, she stated, "We can't confirm it. That's why the plan is being revised to prevent that (access to gloves and inedibles)."</p> <p>The QDP was interviewed on 6/16/15 at 12:40 PM and indicated client B's plan to</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST 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
	address pica dated 1/7/15 indicated he was to be closely monitored. 9-3-4(a)			