

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2012
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1207 W WINONA AVE WARSAW, IN 46580		
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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: September 18, 19, and 20, 2012.</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>Facility number: 000881 Provider number: 15G367 AIM number: 100249180</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 9/21/12 by Tim Shebel, Medical Surveyor III.</p>	W0000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement written policy and procedures to protect 2 of 4 sampled clients (clients #2 and #4) by failing to notify the administrator within 5 working days of the results of 2 of 5 reviewed investigations of potential abuse and neglect.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 9/18/12 at 3:25 PM. The following reports included investigations into the incidents, but none of the investigations were dated as to when the investigation was concluded or when the results were made known to the administrator.</p> <p>-a report dated 2/6/12 indicated client #2 was found with a dollar sized bruise to his inner right bicep.</p> <p>-a report dated 6/2/12 indicated client #4 sustained an injury of unknown origin to his eye.</p> <p>The Residential Coordinator was interviewed on 9/20/12 at 1:30 PM and indicated the investigations were not</p>	W0149	<p><b>W149</b></p> <p><b>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</b></p> <p>Cardinal Services strives to ensure that the people we support are free from abuse and neglect and work towards complying with all ISDH reporting guidelines. In order to ensure that investigations are completed promptly and thoroughly and that Cardinal Services' administrator or representative is notified of investigation results within five business days of an incident, a standardized "Investigation-Person Served" form was revised on September 28, 2012. Residential Managers will be trained on and begin using</p>	10/20/2012			

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	<p>dated as to when they were concluded or when they were sent and to and reviewed by the administrator. She indicated there was no documentation available to indicate when the investigations had been completed or reviewed by the administrator.</p> <p>A review of the facility's "Incident/Abuse/Neglect Policy", dated 7/12 on 9/19/12 at 1:30 PM indicated, the agency "is committed to ensuring the safety, dignity, and protections of persons served." The policy indicated any suspected, alleged or confirmed physical or sexual abuse of a person served must be the reported. "The respective Department Head, Service Coordinators, or Case Manager will conduct an investigation, take appropriate action and write a follow-up report to BDDS with a copy to APS (adult protective services)...describing the incident, the investigation and the actions taken (if any) as a result of the incident. Assigned administrator (Department Head) must sign off on all investigation notes...A follow up report must be completed within 5 days for each incident reported...."</p> <p>9-3-2(a)</p>		<p>this format by October 5, 2012. (See Attachment A)</p> <p>In addition, by October 20, 2012 Residential Managers will review the "Components of a Thorough Investigation" training that was provided to this agency by Steve Corya. (See Attachment B)</p> <p>To ensure that thorough and timely investigations are completed that include the signature of the investigator, date the investigation was concluded and the date the administrator or representative received the results, Coordinators will monitor, receive and review all investigations on an ongoing, as needed basis.</p> <p><b>Residential Manager and Residential Coordinator Responsible</b></p>				

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W0156	<p><b>483.420(d)(4)</b> <b>STAFF TREATMENT OF CLIENTS</b> The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to report the results of an investigation of possible abuse and neglect involving 4 of 4 sampled clients (clients 1#, #2, #3, #4) to the Bureau of Developmental Disabilities Services (BDDS) and other officials within five working days.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 9/18/12 at 3:25 PM. The following reports included investigations into the incidents, but none of the investigations were dated as to when the investigation was concluded or when the results were made known to the administrator.</p> <p>-a report dated 2/16/12 indicated client #2 was found with a dollar sized bruise to his inner right bicep.</p> <p>-a report dated 6/2/12 indicated client #4 sustained an injury of unknown origin to his eye.</p> <p>-a report dated 6/13/12 clients #3 and #2 indicated an incident of possible</p>	W0156	<p><b>W156</b></p> <p><b>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</b></p> <p>In order to ensure that investigations are completed promptly and thoroughly and that Cardinal Services' administrator or representative is notified of investigation results within five business days of an incident, a standardized "Investigation-Person Served" form was revised on September 28, 2012. Residential Coordinators received training on this</p>	10/05/2012			

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	<p>inappropriate sexual activity. -a report dated 6/21/12 indicated client #2 was found in pain and with a swollen left foot and taken to the doctor to be evaluated. The cause of the pain and swelling was unknown in origin.</p> <p>The Residential Coordinator was interviewed on 9/20/12 at 1:30 PM and indicated none of the investigations were dated as to when they were concluded or when they were sent and to and reviewed by the administrator.</p> <p>9-3-2(a)</p>		<p>format by October 5, 2012. Training states that, "The Coordinator must review and sign off on investigations within 5 business days of the incident." (See Attachment A)</p> <p>To ensure that thorough and timely investigations are completed that include the signature of the investigator, date the investigation was concluded and the date the administrator or representative received the results, Coordinators will monitor, receive and review all investigations on an ongoing, as needed basis.</p> <p><b>Residential Coordinator Responsible</b></p>		

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W0249	<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 for 1 of 4 sampled clients (client #3), the facility failed to implement his plan to prevent self injurious behavior as written.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 9/18/12 at 3:25 PM. The reports included incidents dated 2/16/12, 3/16/12, 8/5/12, and 9/5/12 in which client #3 engaged in self injurious behavior of scratching or hitting his face. The report dated 9/5/12 indicated client #3 was now to be within eyesight unless he was in his bedroom or in the bathroom at which time he was to be checked by staff every 10 minutes.</p> <p>Observations were completed in the group home on 9/18/12 from 5:00 PM until 6:00 PM. Client #3 had 2 scratches 4 inches in length along his left cheek with dried blood. At 5:15 PM, client #3 was not</p>	W0249	<p><b>W249</b></p> <p><b>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.</b></p> <p>Cardinal Services believes strongly in providing an environment in which those we support are free from self-harm and offering and following programing that supports this belief. In order to ensure that Client #3 receives the necessary supports to prevent injury from self-abuse staff received training on October 5, 2012 defining</p>	10/05/2012

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	<p>within eyesight of staff in the hallway at the rear of the house as staff #2, #6, #7 were in other rooms of the house.</p> <p>Observations were completed in the group home e on 9/19/12 from 6:46 PM until 9:31 PM. At 8:05 AM, client #3 was not within eyesight in the living room as staff #1, #3, #4, #7 and #8 were in other parts of the house.</p> <p>Client #3's record was reviewed on 9/20/12 at 1:30 PM. An observation protocol dated 3/16/12 indicated client #3 was to be within eyesight when in the common living areas.</p> <p>The Residential Coordinator was interviewed on 9/20/12 at 2:53 PM and indicated client #3 should be within eyesight so staff can intervene when he attempts to injure himself.</p> <p>9-3-4(a)</p>		<p>eyesight supervision and staff responsibility for following plans for the people that they support. (See Attachment H)</p> <p>In order to ensure plan implementation for all men living in this location, including Client #1, the Residential Manager, QDP and Residential Coordinator will monitor through weekly, monthly and quarterly observation.</p> <p><b>Residential Manager, QDP and Residential Coordinator Responsible</b></p>		

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W0302	<p><b>483.450(d)(4)</b> <b>PHYSICAL RESTRAINTS</b> A client placed in restraint must be released from the restraint as quickly as possible. Based on observation, record review and interview the facility failed to ensure the use of restraint (finger control mitts) utilized in 1 of 4 clients' behavior support plans (client #1) indicated he could be released as soon as calm.</p> <p>Findings include:</p> <p>Observations were completed at the group home were conducted on 9/18/12 from 5:00 PM until 6:00 PM. At 5:40 PM, client #3 grabbed staff twice and then grabbed the surveyor's elbow. Staff #7 assisted client #3 to remove his fingers from the surveyor and indicated client #3's plan included the use of finger control mitts for 30 minutes after he attempted to grab three times. Staff #7 attempted to put mitts on client #3's hands, but he removed them.</p> <p>Client #3's record was reviewed on 9/20/12 at 2:06 PM. Client #1's self management plan included the use of finger control mitts for 30 minutes when client #1 attempted to grab three times. The plan did not indicate the mitts would be removed when client #1 was calm.</p> <p>The Residential Coordinator was</p>			W0302	<p><b>W302</b></p> <p><b>A client placed in restraint must be released from the restraint as quickly as possible.</b></p> <p>QMRP's were trained to include specific time frames in client plans which involve releasing the person from the restraint as soon as possible when restrictions such as finger control mitts are part of a persons' plan on 10-3-12. (see attachment C)</p> <p>Client #3 plan was revised to include specific guidelines for the use of restraints (finger control mitts). (see attachment D)</p> <p>Staff were trained on client #3 revised plan on 10-5-12. (see attachment E)</p>		10/05/2012

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	interviewed on 9/20/12 at 2:53 PM. She indicated client #1's plan did not include releasing him from the finger control mitts when calm.  9-3-5(a)		To ensure ongoing compliance, the Human Rights Committee will review plans to ensure the inclusion of specific time frames for restraint removal. QMRP, Managers and Coordinators will observe weekly for correct implementation of the plans. Manager and Coordinator will review incident reports related to the use of restraints to ensure removal is as quickly as possible.  <b>QMRP, Manager and Coordinator responsible</b>		

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W0362	<p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed for 4 of 4 sampled clients, (clients #1, #2, #3 and #4) to provide evidence the pharmacist reviewed their medications on a quarterly basis.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/20/12 at 2:06 PM. There was no evidence of a pharmacist's review of client #1's medications which included, but was not limited to psychotropic medications from 2/27/12 to 6/19/12. There was no further evidence of a signature or date to indicate a pharmacist's review of client #1's medications.</p> <p>Client #2's record was reviewed on 9/19/12 at 3:31 PM. There was no evidence of a pharmacist's review of client #2's medications which included, but was not limited to psychotropic medications from 2/27/12 to 6/19/12. There was no further evidence of a signature or date to indicate a pharmacist's review of client #2's medications.</p>	W0362	<p><b>W362</b></p> <p><b>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</b></p> <p>Cardinal Services has revised the Medication Policy section 35.1 to reflect quarterly review of drug regimen. (see attachment F)</p> <p>The agreement with the Consulting Pharmacist has been revised to include an alternate plan of action in case of inability to fulfill this quarterly responsibility. (see attachment G)</p> <p>To ensure ongoing compliance, nurse will monitor through quarterly quality check.</p>	10/05/2012			

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	<p>Client #3's record was reviewed on 9/20/12 at 1:30 PM. There was no evidence of a pharmacist's review of client #3's medications which included, but was not limited to psychotropic medications from 2/27/12 to 6/19/12. There was no further evidence of a signature or date to indicate a pharmacist's review of client #3's medications.</p> <p>Client #4's record was reviewed on 9/19/12 at 3:45 PM. There was no evidence of a pharmacist's review of client #4's medications which included, but was not limited to psychotropic medications from 2/27/12 to 6/19/12. There was no further evidence of a signature or date to indicate a pharmacist's review of client #4's medications.</p> <p>The Residential Director was interviewed on 9/20/12 at 2:33 PM. She indicated the agency's pharmacist had been unavailable for medical reasons and the reviews of the clients medications was a month late as a result.</p> <p>9-3-6(a)</p>		<p><b>Pharmacist and Nurse responsible</b></p>		

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W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based upon observation, record review, and interview for 1 of 4 sampled clients (client #1), the facility failed to ensure his food was prepared to the consistency as specified in his diet plan.</p> <p>Findings include:</p> <p>Observation were completed in the group home on 9/19/12 from 6:46 AM until 9:31 AM. At 7:16 AM, client #1 was served oatmeal with lumpy consistency.</p> <p>Staff #1 was interviewed on 9/19/12 at 7:30 AM. When asked if client #1's oatmeal was smooth in texture, she stated "It could have been smoother."</p> <p>Staff #12 was interviewed on 9/19/12 at 7:40 AM and indicated client #3 was on a pureed diet.</p> <p>The facility's General Guidelines dated 2/7/08 was reviewed on 9/19/12 at 1:36 PM and indicated "All foods on a puree diet or smooth in texture-just like that of pudding or mashed potatoes. There are NO LUMPS or CHUNKS-it is SMOOTH-period."</p>	W0460	<p><b>W460</b></p> <p><b>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</b></p> <p>Cardinal Services Inc. recognizes the need to modify a persons' diet based on a variety of needs and strives to ensure that all dietary guidelines established by the dietitian and physician are followed. On October 5, 2012 Staff received training regarding Client #1's puree diet stating that all foods on a puree diet must be of a pudding/mashed potato consistency with no lumps. (See Attachment I)</p> <p>The Residential Manager, QDP, Dietitian and Residential Coordinator will monitor the consistent implementation of Client #1's puree diet through weekly, monthly and quarterly observations.</p>	10/05/2012			

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	<p>The Residential Coordinator was interviewed on 9/19/12 at 1:36 PM. She indicated client #3's food should be smooth in texture with no lumps.</p> <p>Client #3's record was reviewed on 9/20/12 at 2:06 PM. His 7/9/12 nutritional assessment indicated he was to be on a pureed consistency diet.</p> <p>9-3-8 (a)</p>		<p><b>Residential Manager, QDP and Residential Coordinator Responsible</b></p>	
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