

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2011
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 N PARK AVE WARSAW, IN46580
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 31, November 1 and 2, 2011</p> <p>Facility number: 003172 Provider number: 15G695 AIM number: 200361630</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/22/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, the governing body failed to exercise operating direction over the facility for 2 of 4 clients (clients #1 and #2) observed during medication administration to ensure all medications were given per their medication policy/med core A and B.</p>	W0104	<p>W 104 The governing body must exercise general policy, budget, and operating direction over the facility. The governing body failed to exercise operating direction over the facility for 2 of 4 clients (Clients #1 and #2) observed during medication administration to ensure all medications were</p>	12/04/2011

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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	<p>Findings include:</p> <p>On 11-1-11 at 6:20 a.m. client #2 was observed during his medication administration. At 6:30 a.m. direct care staff #7 was observed to mix 17 grams of Miralax for constipation into 8 ounces of water. At 6:35 p.m. client #2 was observed to sit at his kitchen table with his cup of water and Miralax. Direct care staff (DCS) #7 went back to the medication closet to begin the medication pass for client #6. At 7:30 a.m. client #1 was observed during his medication administration. DCS #7 was observed to pour a glass of prune juice; he then added the Miralax for constipation and the Milk of Magnesia (MoM) for constipation. At 7:45 a.m. client #1 was observed to sit at the table eating his breakfast with his cup of prune juice, Miralax, and MoM. DCS #7 was observed to go back to the medication closet as client #1 sat at the table with his cup of prune juice/Miralax/MoM. DCS #7 was not observed to stay at the table with clients #1 and #2 to ensure the medications were administered.</p> <p>On 11-1-11 at 9:15 a.m. a record review of the facility's Medication Policy was reviewed. The policy dated 06-11 indicated Medication Core A and B must</p>		<p>given per their medication policy Med Core A and B. On 11/30/2011 training was provided to staff on the proper administration of the medication. Per the medication policy medication must be given by the person who pours it and that staff member is to stay with the person and watch the swallow their medication. (Attachment __A__) Observations completed to ensure competency per the medication policy are attached for review. (Attachment __B__) The QMRP, Residential Manager and Nurse will monitor medication administration through monthly documented observations to ensure that medication is administrated without error and this deficiency does not occur in the future. Nurse, QMRP, and Residential Manager Responsible.</p>		

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W0227	<p>be passed and followed. On 11-1-11 at 11:00 a.m. a review of Medication Core A and B was reviewed. The review indicated the DCS who administered the medications must ensure the medication is taken.</p> <p>On 11-1-11 at 12:30 p.m. an interview with the Residential Coordinator indicated DCS should follow Medication Core A and B and the facility's Medication Policy by ensuring the medications were taken.</p> <p>9-3-1(a)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review, and interview, the facility failed for 1 of 4 sampled clients (client #2) to ensure his Individualized Support Plan (ISP) addressed his speech recommendations to assist him with his communication needs.</p> <p>Findings include:</p> <p>On 11-1-11 at 10:00 a.m. a record review for client #2 was conducted. A communication assessment dated 10-15-10 indicated client #2 had</p>	W0227	<p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. Client #2 was re-assessed on 11-10-11 as to the need for a communication objective per Speech-Language Pathologist Recommendations (see attachment C). Objective was developed based on Communication Assessment dated 10-15-10. (See attachment D) Staff were trained and new objective was implemented for</p>	12/04/2011	

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W0262	<p>diagnoses of mental retardation and total blindness. The Speech-Language Pathologist recommended client #2 should be encouraged to make choices by offering him two objects, placed on his knees. His ISP dated 12-16-10 did not include the recommendation of offering objects on his knees to assist him with his communication needs.</p> <p>On 11-1-11 at 12:30 p.m. an interview with the Residential Coordinator indicated client #2 was visually impaired and his ISP did not include the recommendation from the communication assessment to assist him with his communication needs.</p> <p>9-3-4(a)</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2) to ensure the Human Rights Committee (HRC) signed approvals at a time when all members were present or able to have discussions regarding the use of sedation.</p> <p>Findings include:</p>	W0262	<p>client #2 on 11-17-11. (See attachment E) Coordinator will monitor assessment and goal development through documentation review, internal audits and observation. QMRP will ensure ongoing compliance through observation and monthly review of person served objectives. Coordinator and QMRP Responsible.</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that in the opinion of the committee, involve risks to client protection and rights.</p> <p>Cardinal Services adheres to this regulation by holding bi-monthly meetings with HRC members present to discuss all</p>	12/04/2011	

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	<p>1. On 11-1-11 at 9:00 a.m. a review of the HRC approvals dated 8-31-11 for client #1 was conducted. The review indicated client #1 would need sedation for a biopsy of his knee. The sedation approvals sent out via email were dated and signed by HRC members on 9-1-11. The guardian approval was obtained on 8-31-11.</p> <p>2. On 11-1-11 at 10:00 a.m. a review of the HRC approvals dated 10-31-11 for client #2 was conducted. The review indicated client #2 needed a intervention plan which included the use of a support hold. The intervention plan approvals sent out via email were dated and signed by HRC members on 10-31-11 and 11-1-11. Guardian approval was received on 10-31-11.</p> <p>On 11-1-11 at 12:30 p.m. an interview with the Residential Coordinator indicated HRC meetings are held but in between meetings approvals were being sent out via email with reply to all.</p> <p>9-3-4(a)</p>		<p>plans/decisions. (see Human Rights Schedule of Meetings attachment F) One time per year, HRC reviews the hierarchy of interventions per the Self-Management Policy. (see attachment G) During times between meetings, the HRC is consulted via email and encouraged to "reply all" to the messages so that ample questions and written discussion regarding each issue can be documented and involvement by all members is acknowledged. Guardian approval for sedation of client #1 was obtained August 31, 2011. (See attachment H) Human Rights approval for sedation of client #1 was obtained via email on 9-1-11. (See attachment I) Had the agency waited for the HRC to approve sedation for biopsy of client #1's knee, treatment would have been delayed until after the October 12 th Human Rights Committee meeting, which would not be in the best interest of the client's medical needs. Cardinal Services maintains a strong commitment to quality and timely services as evidenced by the protocol in place to obtain approvals quickly, to communicate discussion among members and as evidenced by the credentials of each Human Rights Committee Member. (see attachments H and I) Coordinator and QMRP will monitor ongoing compliance</p>		

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W0268	<p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, the facility failed for 7 of 7 (clients #1, #2, #3, #4, #5, #6, and #7) who lived in the home, to promote their dignity by not ensuring urinary incontinence pads/towels were not visible on the furniture, for 1 of 4 sampled clients (client #2) to ensure his adult incontinence brief was tucked into his pants, for 1 of 4 sampled clients (client #1) to encourage him to wear clothing which fit appropriately, and for 1 of 4 sampled clients (client #3) to ensure he was offered a clean, dry shirt.</p> <p>Findings include:</p> <p>On 10-31-11 at 2:15 p.m. client #1 was observed to have pants on that were too big. The pants were observed to fall down under his bottom and drag on the ground when he walked. Client #1 was observed to hold his pants up while he walked. At 2:30 p.m. client #1 got up from his chair and walked across the room. His pants fell down and the Residential Manager held his pants up as he walked to a bedroom. At 2:30 p.m. urinary incontinence pads and towels were observed to be on 3 chairs. At 2:35</p>	W0268	<p>through documentation review and internal audits. QMRP and Coordinator Responsible</p> <p style="text-align: center;">W 268</p> <p>Conduct towards client. These policies and procedures must promote the growth, development and independence of the client.</p> <p>The facility failed for 7 of 7 clients who lived in the home, to promote their dignity by not ensuring urinary incontinence pads/towels were not visible on the furniture, for 1 of 4 sampled clients to ensure that his adult incontinence brief was tucked into his pants, for 1 of 4 sampled clients to encourage him to wear clothing which fit properly, and for 1 of 4 sampled clients to ensure he was offered a clean, dry shirt.</p> <p>Cardinal Center's expectation is that each individual we serve be treated with dignity and respect. Staff received training by 11/28/2011 on providing dignity and respect to all individuals supported; which includes their right to a dignified existence free from exposing their personal care items (incontinence items/depends/pads etc.) Additionally, the training consists of also ensuring that clothing properly fits the individual and is neat and clean in appearance. Soiled clothing is to be changed whether from food or bodily fluids to provide for their dignity. (Attachment __L__)</p> <p>Observations completed to ensure competency in providing the consumers dignity and respect are attached for review. (Attachment __B__)</p>	12/04/2011	

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	p.m. the Residential Manager indicated the reason for the pads and towels on the chairs was due to clients #1, #2, #3, #4, #5, #6, #7 and #8 wearing adult incontinence briefs. At 4:00 p.m. client #3 was observed to wear a green shirt with white soiled stains on it. At 4:15 p.m. client #2 was observed to hold his shirt up exposing his adult incontinence brief. At 4:30 p.m. client #3 was observed to drool on his green shirt. At 4:30 p.m. client #1 was observed to have pants on which were too big, his underwear and adult brief were both visible. At 5:00 p.m. client #1 was observed to have on pants which were too big, his underwear and adult brief were still showing. At 5:00 p.m. client #3 was observed to drool on his green shirt with white stains and a soiled wet spot 6 inches by 6 inches. Client #2 again lifted his shirt which showed his adult brief tabs sticking out of his pants. At 5:15 p.m. client #2 walked in circles holding his shirt up which showed his adult brief. At 5:30 p.m. client #1 was observed to walk around his home with his pants under his bottom with his underwear and adult brief showing. At 5:35 p.m. direct care staff #4 was observed to step on the bottom of the pant leg of client #1's pants. Direct care staff #4 pulled up client #1's pants then client #1 went back to his chair and sat down. Client #3 was observed to		The QMRP and Residential Manager will monitor through monthly written observations for positive interactions between clients and staff ensuring that the client's dignity and respect is provided at all times. This will ensure this deficiency does not occur in the future. QMRP and Residential Manager Responsible		

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	<p>continue to wear the soiled, wet, stained, green shirt as he sat at his kitchen table. At 5:40 p.m. client #1 laid in a chair with his pants falling down showing his underwear and adult brief. Client #1 then stood up and was observed to hold his pants up with his hand. At 5:50 p.m. client #1 was observed to leave the supper table. His pants were observed to fall down. The Residential Manager pulled up his pants and assisted him to his chair. Direct care staff #1, #2, #3, and #4 were not observed to assist client #1 with wearing clothes that fit, to assist client #3 to wear a clean shirt, or to redirect client #2 to keep his shirt down.</p> <p>On 11-1-11 from 5:50 a.m. until 8:00 a.m. an observation at the home of client #2 was conducted. At 7:45 a.m. client #2 was observed to walk in a circle holding his shirt up which allowed his adult brief to be seen. At 8:00 a.m. client #2 was observed to walk in a circular motion and hold his shirt up which allowed his adult brief to be seen. Direct care staff #6, #7, #8 and #9 were not observed to redirect client #2 to assist him to keep his shirt down.</p> <p>The Residential Coordinator (RC) was interviewed on 11-1-11 at 12:30 p.m. The RC indicated staff should ensure clients did not remain in soiled clothing,</p>				

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W9999	<p>nor should clients walk through the house with their adult briefs showing, and staff should have offered to assist clients to wear clothes that fit.</p> <p>9-3-5(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division.</p> <p>This state rule was not met as evidenced by:</p>	W9999	<p>W9999 The residential provider shall report the following circumstances to the division by telephone/email no later than the first business day followed by written summaries as requested by the division. The facility failed to report timely to BDDS, 4 of 41 BDDS reports for 3 of 7 clients in the home. Cardinal Services Inc.'s Incident/Abuse/Neglect policy is currently in place to ensure that all allegations of neglect, abuse as well as significant injuries are reported to the appropriate administer and BDDS timely. Direct Support Professionals were retrained by 11/22/2011 the Incident/Abuse/Neglect policy. All</p>	12/04/2011	

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	<p>Based on record review and interview, the facility failed to report timely to the Bureau of Developmental Disabilities Services (BDDS), 4 of 41 initial BDDS reports for 3 of 7 clients who lived in the home (clients #5, #6, and #7).</p> <p>Findings include:</p> <p>Facility records were reviewed on 10-31-11 at 12:15 p.m., including BDDS reports for the time period between 11-1-10 and 10-31-11. The BDDS reports indicated the following:</p> <ul style="list-style-type: none"> - A BDDS report for an incident on 4-23-11 involving a medication error for client #7 indicated client #7 did not receive his medication Amoxicillin for 2 days. This incident was reported to BDDS on 4-25-11. - A BDDS report for an incident on 3-11-11 which indicated client #5 was given a double dose of his Risperdal had a report date to BDDS on 3-14-11. - A BDDS report for an incident on 3-22-11 which indicated client #6 was discharged from the hospital had a report date to BDDS on 3-24-11. - A BDDS report for an incident on 4-1-11 which indicated client #6 was 		<p>incidents are required to be reported to BDDS within 24 hours of the incident. (Attachment __M__) All incidents meeting reporting requirements will be reported immediately to the appropriate person(s) as determined in the policy. The Residential Coordinator will monitor all incident reports weekly to ensure accuracy and timely reporting. The Residential Manager will be responsible for ensuring Direct Support Professionals are filing reportable incidents with BDDS timely. This will ensure the deficiency does not occur in the future.</p> <p>Residential Coordinator and Residential Manager Responsible</p>	

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	<p>discharged from his home per Medicaid guidelines due to being at the hospital/nursing home. The BDDS report had a report date to BDDS of 4-4-11.</p> <p>On 10-31-11 at 1:00 p.m. a review of the facility's BDDS reports did not indicate initial reports for the above listed incidents were done within 24 hours.</p> <p>A review of the BDDS reporting policy dated 3-1-11 was conducted on 11-2-11 at 5:00 p.m. The policy indicated initial reportable incidents are to be reported within 24 hours.</p> <p>An interview with the Residential Coordinator was conducted on 11-1-11 at 12:30 p.m. He indicated BDDS initial reports should be completed within 24 hours of the incident.</p> <p>9-3-1(b)</p>				