

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G651	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2016
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 628 ROSS AVE WARSAW, IN 46580
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 1/12, 1/13, 1/14, 1/19, 1/20, 1/25, and 1/26/2016.</p> <p>Facility Number: 001181 Provider Number: 15G651 AIMS Number: 100234730</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/1/16.</p>	W 0000		
W 0268 Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview, and record review, for 2 of 4 sampled clients (clients #3 and #4), the facility failed to ensure clients #3 and #4's dignity in regard to client #3's personal privacy and client #4's stained shirt savers.</p> <p>Findings include:</p>	W 0268	<p>W 268</p> <p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Cardinal Services 'expectation is that each individual we serve be treated with dignity and respect. All direct support staff working at the Ross</p>	02/25/2016

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>1. On 1/12/16 from 3:30pm until 5:55pm and on 1/13/16 from 6:30am until 8:25am, client #3 was observed at the group home. During both observation periods client #3 did not wear a belt on his pants. On 1/12/16 from 3:30pm until 5:55pm, client #3's jeans sagged below his waist, fell to his ankles four (4) times, and facility staff failed to teach and encourage the use of a belt. On 1/13/16 from 6:30am until 8:25am, client #3's jeans sagged below his waist, client #3 held the waist band of his jeans with one hand to hold his pants up, and when client #3 walked and let go of the waist band the jeans fell to client #3's ankles twice. Facility staff prompted client #3 to pull up his pants and did not prompt client #3 to wear a belt or change his pants.</p> <p>Client #3's record was reviewed on 1/14/16 at 3:35pm and on 1/125/16 at 10:30am. Client #3's 8/14/15 ISP (Individual Support Plan) indicated client #3 needed staff verbal prompting for dressing. Client #3's record did not include a goal/objective for dressing.</p> <p>On 1/13/16 at 11:00am, an interview with the agency Licensed Practical Nurse (LPN), the Residential Coordinator (RC), and the QIDP (Qualified Intellectual Disabilities Professional) was conducted.</p>		<p>Avenue group home received additional training on dignity and respect on 2/4/16 (see attachment A). Day services staff working directly with Client #3 received training on dignity and respect on 2/8/16 (see attachment B). A goal was implemented for Client # 3 on 2/5/16 to address the use of a belts and clothing that fits securely to the body (see attachment C). Direct support staff working at the Ross Ave group home received additional training on Client # 3's goal on 2/5/16 (see attachment D).</p> <p>To ensure this deficiency does not occur again, the Residential Manager, QDP and Coordinator will monitor the implementation of all goals and dignity and respect through weekly, monthly, and quarterly observations.</p> <p>Residential Manager, QDP, and Coordinator responsible.</p>				

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	<p>The RC and QIDP both indicated client #3 should have been taught and encouraged to wear a belt to hold up his pants. The RC indicated client #3's belt had broken sometime earlier and he did not have a belt available. The RC indicated staff failed to ensure client #3's dignity when he was not prompted to wear pants that fit his body type.</p> <p>2. On 1/12/16 from 3:30pm until 5:55pm and on 1/13/16 from 6:30am until 8:25am, client #4 was observed at the group home. During both observation periods client #4 wore a shirt saver at meal times around his neck that was a brown color. On 1/12/16 at 5:50pm, GHS (Group Home Staff) #2 applied a brown colored shirt saver around client #4's neck. At 5:50pm, GHS #2 stated client #4's shirt saver "was not brown, but white" colored. When asked regarding the color, GHS #2 stated "It used to be white. It's worn, holey, could be considered brown (colored) I guess." GHS #2 stated client #4's shirt saver "needed to be replaced" and was old. On 1/13/16 at 7:18am, GHS #3 applied a torn brown colored shirt saver around client #4's neck at the dining room table. GHS #3 stated client #4's shirt saver coverings were "worn, stained, and discolored."</p>			

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W 0331 Bldg. 00	<p>Client #4's record was reviewed on 1/14/16 at 10:05am and on 1/25/16 at 1:00pm. Client #4's 9/18/15 ISP indicated he used a shirt saver during meals to protect his clothing and his dignity.</p> <p>On 1/13/16 at 11:00am, an interview with the agency Licensed Practical Nurse (LPN), the Residential Coordinator (RC), and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The RC and QIDP both indicated stained, worn, and discolored shirt savers should be replaced at the group home. The RC indicated the shirt savers at the group home needed to be replaced. The RC indicated client #4 should not wear stained, torn, and worn shirt savers.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility's nursing services failed to develop protocols specific to client #4 to monitor and to manage his pain.</p> <p>Findings include:</p>	W 0331	<p>W331</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>The Residential Nurses received training regarding the development of client specific care plans on 2/9/16</p>	02/25/2016

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	<p>On 1/12/16 from 3:30pm until 5:55pm and on 1/13/16 from 6:30am until 8:25am, client #4 was observed at the group home. During both observation periods client #4 was not prompted and did not use sign language to communicate his wants/needs. During both observation periods client #4 used a walker to walk slowly from room to room at the group home, made facial grimaces when he shifted his weight from one leg to the other, and used sign language to say hello to the Surveyor. During both observation periods GHS (Group Home Staff) #1, GHS #2, GHS #3, GHS #4, GHS #5, and the Residential Manager (RM) did not use sign language to communicate with client #4. On 1/13/16 at 8:25am, the RM, GHS #1, and GHS #3 indicated the group home staff did not know sign language to communicate with client #4.</p> <p>On 1/13/16 at 6:35am, GHS (Group Home Staff) #1 asked client #4 to come to the medication closet at the group home. GHS #1 asked client #4 to sign his name, client #4 signed his name, and staff acknowledged client #4 was correct. GHS #1 selected client #4's Ammonium Lactate Lotion 12%" to treat his "scaly and dry skin" on his feet. Client #4 removed his shoes and socks, then GHS</p>		<p>(see attachment E). The Nurse developed a care plan specific to Client # 4's needs to address pain management on 2/1/16 (see attachment F). All direct support staff working in Client # 4's home received training on this plan on (see attachments G). All support staff working with Client # 4 received training on Raynaud's Syndrome and Skin Breakdown on 2/2/16 (see attachments H & I). All support staff working with Client 4 during day services received training on 2/4/16 (see attachments J). Additionally all direct support staff working in Client 4's home received training on Pain Management Instructions on 2/4/16 (see attachment K). A communication book that contains the sign for pain was implemented for Client 4 on 1/21/16. All staff received training on how to sign the words in Client 4's communication book during the house meeting on 1/21/16. All support staff in Client # 4's home have reviewed the communication book (see attachment L).</p> <p>To ensure this deficiency does not occur in the future, the Coordinator will monitor care plans for thoroughness in amendments through documentation review and internal audits. Spot checks will be completed by the Coordinator monthly and each time a new care plan is implemented it will be reviewed for thoroughness and accuracy. The Residential Manager,</p>	

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	<p>#1 stated client #4's peeling skin on his right lower leg/foot was "a dark red, purplish, and brown" color. GHS #1 indicated client #4's skin areas on his right and left lower legs extended from just above each ankle to the end of each of his five toes on each foot. GHS #1 indicated client #4 did not have guidelines which would alert staff that client #4 was in pain. GHS #1 indicated client #4 had not complained of pain today. GHS #1 stated client #4 was non verbal and the staff "can usually tell" if something was not right with client #4. GHS #1 indicated she did not use sign language to communicate with client #4 because she did not know sign language. GHS #1 stated she "knew" what client #4's name was when he used sign language. When asked how she could tell client #4 was in pain, GHS #1 stated "I just know" when client #4 was in pain.</p> <p>Client #4's record was reviewed on 1/14/16 at 10:05am and on 1/25/16 at 1:00pm. Client #4's 10/27/15 Physician's Order indicated client #4 had as needed pain medications which were to be used when client #4 had pain/discomfort. Client #4's 9/18/15 ISP (Individual Support Plan) indicated a goal/objective to use sign language to state the day of the week. Client #4's record indicated he was non verbal, was able to use basic</p>		<p>QDP, and Coordinator will ensure ongoing compliance through weekly, monthly and quarterly observations.</p> <p>Support Services Coordinator, Residential Nurse, and Residential Manager responsible</p>				

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	<p>sign language, and used gestures/pointing to communicate his wants/needs. Client #4's record did not indicate a pain assessment available for review. No information was available for review to determine how and if client #4 was able to identify his pain. No information was available for review to determine if client #4's pain medication was effective and no information was available for review to determine if the pain medication was effective to control client #4's pain. No guidelines or protocols for client #4's pain were available for review.</p> <p>On 1/13/16 at 11:00am, an interview with the agency Licensed Practical Nurse (LPN), the Residential Coordinator (RC), and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The LPN indicated client #4 had physician's orders for as needed pain medications and should receive the pain medication when client #4 appeared to be in pain/discomfort. The LPN and the RC both stated "No, [client #4] did not have a completed pain assessment" available for review. The LPN indicated client #4 had been seen by multiple physicians related to client #4's lower legs being discolored and the agency nurses continue to follow up to ensure client #4's lower leg skin was kept intact.</p>			

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W 0369 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 1 of 10 medications administered during the morning medication administration (client #4), the facility failed to ensure client #4's medication was given without error.</p> <p>Findings include:</p> <p>On 1/13/16 at 6:35am, client #4 was asked by GHS (Group Home Staff) #1 to come into the medication closet. At 6:35am, GHS #1 selected client #4's "Polyethylene Glycol 3350 (Miralax Powder), take 1 capful (or) 17gm (grams) in 8oz (ounces) of fluid twice daily" for constipation. GHS #1 compared the medication label to client #4's 1/2016 MAR (Medication Administration Record), selected the medication container's clear plastic cap which had a line half way up the side of the cap to indicate 17 grams, poured the medicated powder to the top of the clear plastic cap measuring 34 grams of medication, mixed the medication with water, and</p>	W 0369	<p>W369</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Cardinal Services, Inc. has in effect procedures to assure safe and responsible administration of prescription and non-prescription medication as well as a tracking process to provide training and discipline for non-compliance. Staff #1 has not administered medications since this medication error occurred on 1/13/16 due to needing to attend Med Core A training. Staff # 1 will be attending the next scheduled Med Core A training on 2/9/16 (see attachment M). All direct support staff working in the home received additional training on Medication Pass Procedures on 2/4/16 (see attachment N).</p> <p>To ensure this deficiency does not occur again, the Residential Manager, QDP, Nurse and Coordinator will monitor the administration of medications</p>	02/25/2016

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	<p>client #4 drank the medication mixture.</p> <p>Client #4's record was reviewed on 1/14/16 at 10:05am and on 1/25/16 at 1:00pm. Client #4's 10/27/15 Physician's Order indicated "Polyethylene Glycol 3350 (Miralax Powder), take 1 capful (or) 17gm (grams) in 8oz (ounces) of fluid twice daily" for constipation.</p> <p>On 1/14/16 at 11:30am, 3/2015 policy and procedures for "Medication Administration" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders and the pharmacy instructions should be followed.</p> <p>On 1/14/16 at 11:30am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders and the pharmacy instructions.</p>		<p>through weekly, monthly and quarterly unannounced observations.</p> <p>Residential Manager, QDP, Nurse, and Coordinator responsible</p>		

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W 0436 Bldg. 00	<p>On 1/13/16 at 11:00am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. The agency nurse indicated client #4 should have been given 17 grams of Miralax medication or half a capful of the medication on 1/13/16.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #2) with adaptive equipment, the facility failed to have client #2's prescribed eye glasses available and encourage client #2 to wear his prescribed eye glasses when opportunities existed.</p>	W 0436	<p>W 436</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces and other devices identified by the interdisciplinary team as needed by the client.</p>	02/25/2016

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	<p>Findings include:</p> <p>On 1/12/16 from 3:30pm until 5:55pm and on 1/13/16 from 6:30am until 8:25am, client #2 was observed at the group home. During both observation periods client #2 was observed at the group home and did not wear his prescribed eye glasses. During the observation period the facility staff did not encourage client #2 to wear his prescribed eye glasses. During both observation periods client #2 fed himself a meal, completed medication administration, colored on paper, watched television, stirred a pitcher of drink, and matched color markers to his picture.</p> <p>Client #2's record was reviewed on 1/14/16 at 2:55pm and on 1/25/16 at 11:00am. Client #2's 7/8/15 ISP (Individual Support Plan) did not indicate a goal to wear his prescribed eye glasses. Client #2's ISP indicated a list of adaptive equipment which included prescribed eye glasses. Client #2's 11/20/15 visual examination indicated client #2 wore prescribed eye glasses to see.</p> <p>On 1/13/16 at 11:00am, an interview with the agency Licensed Practical Nurse (LPN), the Residential Coordinator (RC), and the QIDP (Qualified Intellectual</p>		<p>An informal goal was implemented on 2/5/16 for Client # 2 to be encouraged to wear his eye glasses as prescribed by his Optometrist (see attachment O). All direct support staff working in the home received training on this goal on 2/5/16 (see attachment P). Additionally, all direct support staff working in the home received training in regards to eye glass use and encouraging individuals to wear them as prescribed on 2/4/16 (see attachment Q).</p> <p>To ensure this deficiency does not occur again, the Residential Manager, QDP, and Residential Coordinator will monitor the implementation of Client 2's use of eye glasses through weekly, monthly, and quarterly observations.</p> <p>Residential Manager, QDP, and Coordinator responsible</p>	

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	<p>Disabilities Professional) was conducted. The RC, LPN, and QIDP indicated client #2 should be encouraged to wear her prescribed eye glasses to see. The LPN and RC both indicated client #2 wore prescribed eye glasses.</p> <p>9-3-7(a)</p>				