

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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
W000000	<p>This visit was for an extended annual recertification and state licensure survey to a fundamental survey (Client Protections).</p> <p>Dates of Survey: January 15, 16, 20, 21, 23, and 27, 2015.</p> <p>Facility Number: 001208 Provider Number: 15G632 AIMS Number: 100240170</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/10/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and</p>	W000104	On 1/26/15 and 2/16/15 the Residential Manager and QDP were retrained on quality	02/26/2015

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:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>interview for 2 of 4 sampled clients (#1, #2) and 2 additional clients (#5, #7), the governing body neglected to develop and/or implement a system to identify, report, thoroughly investigate, and prevent neglect and/or abuse. The governing body failed to prevent and thoroughly investigate an allegation of neglect in regards to elopement. The governing body failed to prevent and investigate an allegation of neglect in regards to ingestion of a cleaning product for a client with a history of stealing food and fluids. The governing body failed to prevent recurrent falls and investigate a fall which resulted in significant injury (broken nose). The governing body failed to prevent, report to the state agency, investigate, and provide sufficient corrective action for a fall due to an environmental hazard (wet floor) caused by staff. The governing body failed to prevent medical neglect in regards to ensuring updated fall plans, accurate fall plans which included use of gait belt and clear levels of supervision for clients with history of recurrent falls.</p> <p>Based on record review and interview, the governing body failed to ensure a recordkeeping system which accurately documented the clients' current physician's orders throughout all ISP (Individual Support Plan) plans and at</p>		<p>investigations, including thoroughness, investigating significant injuries, when a plan didn't work, peer to peer aggression, patterns or trends, abuse/neglect, unknown injuries, serious injuries, anything with potential to cause significant injury, and anything that is suspicious in nature. The QDP and RM were also retrained to include the who, what, when, where and whys of an investigation on the investigation document. (See attachment A - J) Additionally the RM, QDP, and agency nurse were trained on a new system for ensuring all recommendations from the IDT and/or medical facility are updated in the plans and trained to staff. Furthermore, the RM, QDP, and agency nurse were trained on a new procedure that ensures the most current plan is in the home file and office file. (see attachment A-D) The RM and QDP were trained that all falls will require an investigation to determine is staff followed person served plan, if the fall could have been prevented, if there was an environmental issue noted that caused the fall, and if the plan was effective. Additionally, any fall that results in significant injury will be viewed as possible neglect and staff will be suspended and investigated per the agency's Incident/Abuse/Neglect policy(see attachment B &amp; K-R) Residential</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>every setting the client receives services for 1 of 4 sampled clients (#2) and 2 additional clients (#5, #7).</p> <p>Findings include:</p> <p>1. Please see W149. The governing body failed to ensure thorough investigation of an allegation of neglect in regards to elopement for 1 of 4 sampled clients (#1). The governing body failed to prevent and investigate an allegation of neglect in regards to ingestion of a hazardous material (cleaning product) for a client with a history of stealing food and fluids for 1 of 4 sampled clients (#2). The governing body failed to prevent recurrent falls and to investigate a fall which resulted in significant injury and a fall which had the potential for significant injury (fall into the bathtub) for 1 additional client (#5). The governing body failed to prevent recurrence of falls and to investigate a fall from an accident hazard (wet floor) caused by staff for 1 of 4 sampled clients (#1) and 1 additional client (#7). The governing body failed to prevent medical neglect in regards to ensuring fall plans were implemented as written, to update fall plans as necessary to prevent recurrence, to ensure fall plans were accurate and included updated PT (physical therapy) recommendations, to</p>		<p>Manager, QDP, and Nurse, Director responsible</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>ensure fall plans included the use of gait belt, to ensure fall plans clearly indicated the level of supervision required for clients requiring assistance for ambulation, to ensure dysphagia (swallowing disorder) risk plans had accurate physician prescribed diet orders and to ensure an accurate medical record keeping system to ensure accurate physician orders for diet and ambulation were uniformly documented for 2 of 4 sampled (#1, #2) and 2 additional clients (#5, #7).</p> <p>2. Please see W153. The governing body failed to report to the state agency (Bureau of Developmental Disabilities Services) an allegation of neglect in regards to a fall due to an accident hazard (wet floor) for 1 of 4 sampled clients (#1).</p> <p>3. Please see W154. The governing body failed to thoroughly investigate an allegation of neglect in regards to an elopement for 1 of 4 sample clients (#1). The governing body failed to thoroughly investigate an allegation of neglect in regards to a fall caused by an accident hazard (wet floor) for 1 of 4 sampled clients (#1). The governing body failed to thoroughly investigate an allegation of neglect in regards to ingestion of a cleaning product for 1 of 4 sampled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>clients (#2). The governing body failed to thoroughly investigate falls with significant injury (broken nose) and/or the potential for significant injury (fall into the bathtub) for 1 additional client (#5).</p> <p>4. Please see W157. The governing body failed to implement sufficient corrective action in regards to a fall due to an accident hazard (wet floor) caused by staff mopping for 1 of 4 sampled clients (#1).</p> <p>5. Please see W331. The governing body failed to ensure nursing services were provided in accordance with client needs in regards to ensuring a fall plan was implemented as written to prevent recurrence of falls for 1 of 4 sampled clients (#1), failed to ensure a physician prescribed diet order was accurate in a dysphagia (swallowing disorder) plan in the client record book for 1 of 4 sampled clients (#2), failed to ensure a fall care plan was implemented as written, was revised as necessary to prevent recurrence of falls, and failed to include the use of a gait belt in the client's fall risk plan for 1 additional client (#5), failed to ensure a physician prescribed diet order was accurate in a dysphagia plan, to update a fall plan as necessary and to include updated PT (physical</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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
W000111	<p>therapy) recommendations to prevent recurrent falls for 1 additional client (#7).</p> <p>9-3-1(a)</p> <p>483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. Based on record review and interview, the facility failed to develop and/or maintain a recordkeeping system which accurately documented the clients' current physician's orders throughout all ISP (Individual Support Plan) plans and at every setting the client receives services for 1 of 4 sampled clients (#2) and 2 additional clients (#5, #7).</p> <p>Findings include:</p> <p>1) On 1/21/15 at 4:21 PM, record review indicated Client #2's diagnoses included, but were not limited to, severe intellectual disabilities, cerebral palsy, anxiety disorder, and ADHD (attention deficit hyperactivity disorder). Client #2's ISP (Individual Support Plan) dated</p>	W000111	<p>On 1/26/15 and again on 2/16/15, the agency nurse, QDP and Residential Manager (RM) were trained on an updated system to ensure all recommendations, whether by the IDT and/or a medical facility, was updated in person served ISP plans. (See attachments D-G and S-T). Client #2's dysphasia risk plan, which was correct in the home file, has been placed in the office file. Client #5's fall risk plan has been updated to include the use of the gait belt. Additionally, his 90 day physician order does state he needs a gait belt. (See attachment W) Between the dates of 2/11/15 – 2/17/15 staff were trained on client #5's updated fall plan. (See attachments U &amp; V). Furthermore, between 2/11/15 – 2/17/15, staff</p>	02/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>3/27/14 indicated Client #2 had a "Risk Plan Compilation" which indicated (not all inclusive) a "Dysphagia" risk plan which indicated Client #2 "has a history of eating too fast and stealing food which is a choking risk." Client #2's dysphagia risk plan in his record book indicated a diet of "mechanical soft."</p> <p>Record review indicated Client #2's physician's orders dated 1/1/15 included a physician's order for "puree" diet.</p> <p>On 1/23/15 at 2:05 PM during an interview, the House Manager (HM) indicated Client #2's dysphagia risk plan indicated "puree diet" and provided documentation from the group home. The HM indicated the nurse and QIDP (Qualified Intellectual Disabilities Professional) were new to their positions and were in the process of auditing all the documentation for accuracy. The HM indicated she thought the QIDP had changed the diet order to puree when Client #2's diet order changed but did not update the record book in the office.</p> <p>2) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A</p>		<p>received general gait belt training (see attachments X &amp; Y)</p> <p>Between 2/11/15-2/17/15 staff were trained on client #7's updated fall plan. His updated fallplans includes the number of people needed to assist him while ambulating and anew bathroom protocol to help reduce falls. (See attachments Z – cc)</p> <p>To ensure these deficiencies are not repeated, the agencyhas implemented two new procedures that involve the IDT working together andholding each other accountable for ensuring all plans and files are updated perrecommndation. This will serve as an ongoing monitoring system. Residential Manager, QDP, Nurse, and Director responsible.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>BDDS report dated 10/5/14 indicated "On 10-5-14 [Client #5] was drying off in the bathroom after his shower. [Client #5] lost his balance and fell backwards onto the wall and ending [sic] up sliding into the tub. [Client #5] has a 1/2 to 3/4 of an inch scratch on his upper left buttocks and possible bruising." The report indicated "[Client #5]'s team will continue to follow his fall plan to prevent future falls from taking place. If a pattern of falls develops [Client #5]'s team will meet to review his current fall plan."</p> <p>A BDDS report dated 10/8/14 indicated "staff was helping a consumer get out of bed when [Client #5] starting [sic] getting up by himself. Staff asked for him to wait a minute while she finished with the other consumer. Staff was on the left side of [Client #5], when [Client #5] got up on right side of his bed and started going towards the bathroom." The report indicated "[Client #5] tripped over a chair in the room rushing to get to the bathroom. When [Client #5] fell, he hit his nose on the floor and it began bleeding. The staff followed precautions for universal Blood [sic] and body fluid by wearing gloves, cleaning area and disposal. The staff took him to the [emergency room] where the Doctor stopped the bleeding and said that [Client #5] [sic] nose was broken. He also stated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506		
(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>that there was no reason to do an X-ray or reset the nose except for appearance." The report indicated "the chair was removed from his room. Staff will continue to follow his fall plan."</p> <p>A follow up BDDS report dated 10/14/14 indicated "[Client #5] is doing well. He has had no further issues with his nose. He has not complained of pain or indicated that his nose is bothering him." The report indicated "[Client #5] does not need to see his physician for any additional follow up. Staff continue to assist [Client #5] when he ambulates, as he tends to walk quickly."</p> <p>On 1/21/15 at 1:58 PM, record review indicated Client #5's diagnoses included, but were not limited to, profound intellectual disabilities, autism, severe organic dysfunction, and agitated behavior organic personality syndrome. Client #5's ISP (Individual Support Plan) dated 10/10/14 indicated Client #5 "needs assistance while ambulating. [Client #5] is unsteady when he first stands from a seated position. He has a Fall Management plan in place to include a gait belt so staff can help him steady himself before he ambulates." Client #5's ISP indicated "[Client #5] has injured himself in the past by moving too quickly, when he becomes agitated."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>Record review indicated Client #5 had a "Risk Plan Compilation" dated 10/10/14 which indicated a "Fall Management Plan". Client #5's fall plan indicated "has a history of getting up quickly and walking too fast which can cause falling." The plan indicated the following "interventions":</p> <p>"*Staff should walk with me when there is any type of terrain changes due to being unsteady from seizure medication.</p> <p>*Staff should be aware that I move quickly when getting out of seated position and initiating ambulating from place to place and be there for support and stability if I need it.</p> <p>*I utilize a shower chair due to general dizziness and poor balance. I use shower chair to help me from falling in the shower. Staff will assist in washing and transferring in and out of my shower chair while showering."</p> <p>Client #5's fall plan indicated staff should monitor "terrain changes", "transferring to and from seated position", and "showering." Client #5's fall plan did not indicate use of gait belt.</p> <p>Record review indicated Client #5's</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506		
(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>physician's orders dated 1/1/15 indicated no order for a gait belt.</p> <p>Record review indicated Client #5 had a PT (physical therapy) appointment on 12/12/12 which indicated the recommendation "gait belt placement at hips or chest depending caregiver preference c (with) belt height, holding onto back of belt in center/midline." Record review indicated Client #5 had a PT appointment on 12/22/14 which indicated "continue current program."</p> <p>On 1/23/15 at 2:05 PM in a concurrent interview, the Administrator indicated Client #5's physician's orders did not indicate an order for the gait belt. The House Manager (HM) indicated Client #5 does use a gait belt in the home. The HM stated Client #5's use of gait belt was in "his original plan" but did not get transferred over to "the new compilation" format. The HM indicated the facility nurse and QIDP (Qualified Intellectual Disabilities Professional) were new to their positions and were beginning to audit the records to ensure accuracy. She indicated Client #5's fall risk plan should be updated to include use of gait belt and a bathroom safety protocol.</p> <p><b>3)</b> On 1/21/15 at 2:03 PM, record review indicated Client #7's diagnoses, included</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>but were not limited to, profound intellectual disabilities, OCD (obsessive compulsive disorder), organic personality disorder, probable seizures, and Parkinson's disease. Client #7's physician's order dated 1/1/15 indicated "staff to use gait belt to assist with ambulation."</p> <p>Record review indicated Client #7's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #7] has some difficulty getting up from his favorite chair, staff should not pull him up, but encourage him to get up on his own, with an assistive device, if necessary." Client #7's ISP indicated a "Risk Plan Compilation" dated 7/24/14 which did not indicate Client #7 had a current fall risk plan or indication for gait belt use.</p> <p>Record review indicated Client #7 had an PT (physical therapy) appointment on 10/17/13 which indicated "gait belt to assist with ambulation." Record review indicated Client #7 had a PT appointment dated 12/31/14 which indicated the recommendation "continue assist c (with) 2 (staff) and continue yearly eval (evaluation)."</p> <p>On 1/23/15 at 2:05 PM during a concurrent interview, the Administrator indicated the House Manager (HM)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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
W000122	<p>usually ensures fall plans were followed and assesses the environment routinely for fall hazards. The House Manager (HM) indicated Client #7's "Risk Plan Compilation" in the record book in the office was an incorrect version. The HM stated Client #7's current fall risk plan indicated "staff will assist" but did not indicate how many staff. The HM indicated the fall risk plan was not updated to include the 12/31/14 PT (physical therapist) recommendation for Client #7 to ambulate with 2 staff assistance with use of gait belt.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, record review, and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (#1, #2) and 2 additional clients (#5, #7). The facility neglected to develop and/or implement a system to identify, report, thoroughly investigate, and prevent neglect and/or abuse. The facility failed</p>	W000122	<p>On 1/26/15 and 2/16/15 the Residential Manager and QDP were retrained on quality investigations, including thoroughness, investigating significant injuries, when a plan didn't work, peer to peer aggression, patterns or trends, abuse/neglect, unknown injuries, serious injuries, anything with potential to cause significant injury, and anything that is suspicious in nature. The QDP</p>	02/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>to prevent and thoroughly investigate an allegation of neglect in regards to elopement. The facility failed to prevent and investigate an allegation of neglect in regards to ingestion of a cleaning product for a client with a history of stealing food and fluids. The facility failed to prevent recurrent falls and investigate a fall which resulted in significant injury (broken nose). The facility failed to prevent, report to state agency, investigate, and provide sufficient corrective action for a fall due to an environmental hazard (wet floor) caused by staff. The facility failed to prevent medical neglect in regards to ensuring updated fall plans, accurate fall plans which included use of gait belt and clear levels of supervision for clients with history of recurrent falls.</p> <p>Findings include:</p> <p>1. Please see W149. The facility failed to ensure thorough investigation of an allegation of neglect in regards to elopement for 1 of 4 sampled clients (#1). The facility failed to prevent and investigate an allegation of neglect in regards to ingestion of a hazardous material (cleaning product) for a client with a history of stealing food and fluids for 1 of 4 sampled clients (#2). The facility failed to prevent recurrent falls</p>		<p>and RM were also retrained to include the 'who, what, when, where and whys' of an investigation on the investigation document. The agency director must review and approve all investigations. (See attachment A - J) Additionally the RM, QDP, and agency nurse were trained on a new system forensuring all recommendations from the IDT and/or medical facility are updated in the plans and trained to staff. Furthermore, the RM, QDP, and agency nurse were trained on a new procedure that ensures the most current planis in the home file and office file. (see attachment A-D) The RM and QDP were trained that all falls will require an investigation to determine is staff followed person served plan, if the fall could have been prevented, if there was an environmental issue noted that caused the fall, and if the plan was effective. Additionally, any fall that results insignificant injury will be viewed as possible neglect and staff will be suspended and investigated per the agency's Incident/Abuse/Neglect policy (see attachment B &amp; K-R). To ensure this deficiency does not occur again, a new protocol was implemented to monitor plans, IDT recommendations, and investigations. (See attachments dd-ff) This is an ongoing monitoring system. Additionally, the Director will</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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 to investigate a fall which resulted in significant injury and a fall which had the potential for significant injury (fall into the bathtub) for 1 additional client (#5). The facility failed to prevent recurrence of falls and to investigate a fall from an accident hazard (wet floor) caused by staff for 1 of 4 sampled clients (#1) and 1 additional client (#7). The facility failed to prevent medical neglect in regards to ensuring fall plans were implemented as written, to update fall plans as necessary to prevent recurrence, to ensure fall plans were accurate and included updated PT (physical therapy) recommendations, to ensure fall plans included the use of gait belt, to ensure fall plans clearly indicated level of supervision required for clients requiring assistance for ambulation, to ensure dysphagia (swallowing disorder) risk plans had accurate physician prescribed diet orders and to ensure an accurate medical record keeping system to ensure accurate physician orders for diet and ambulation were uniformly documented for 2 of 4 sampled (#1, #2) and 2 additional clients (#5, #7).</p> <p>2. Please see W153. The facility failed to report to the state agency (Bureau of Developmental Disabilities Services) an allegation of neglect in regards to a fall due to an accident hazard (wet floor) for 1 of 4 sampled clients (#1).</p>		<p>monitor home files and office files quarterly to ensure plans match and all recommendations have been included in the plans. Additionally, DSPs were retrained on the agency's Incident/Abuse/Neglect policy on 2/16/15. (see attachment gg &amp; K-R). To ensure DSPs are recognizing the differences between an internal accident report and a BDDS incident report, employees are quizzed on the differences between reportable incidents during observations. Additionally, the RM and QDP have been retrained to check the internal accident reports daily to ensure staff reported accurately. In the event staff fail to identify an incident correctly, immediate retraining will occur. The QDP and Manager will monitor reports daily and quiz staff during weekly observations. Residential Manager, QDP, and Nurse, Director responsible</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>3. Please see W154. The facility failed to thoroughly investigate an allegation of neglect in regards to an elopement for 1 of 4 sample clients (#1). The facility failed to thoroughly investigate an allegation of neglect in regards to a fall caused by an accident hazard (wet floor) for 1 of 4 sampled clients (#1). The facility failed to thoroughly investigate an allegation of neglect in regards to ingestion of a cleaning product for 1 of 4 sampled clients (#2). The facility failed to thoroughly investigate falls with significant injury (broken nose) and/or the potential for significant injury (fall into the bathtub) for 1 additional client (#5).</p> <p>4. Please see W157. The facility failed to implement sufficient corrective action in regards to a fall due to an accident hazard (wet floor) caused by staff mopping for 1 of 4 sampled clients (#1).</p> <p>5. Please see W331. The facility nursing staff failed to ensure a fall plan was implemented as written to prevent recurrence of falls for 1 of 4 sampled clients (#1), failed to ensure a physician prescribed diet order was accurate in a dysphagia (swallowing disorder) plan in the client record book for 1 of 4 sampled clients (#2), failed to ensure a fall care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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
W000149	<p>plan was implemented as written, was revised as necessary to prevent recurrence of falls, and failed to include the use of a gait belt in the client's fall risk plan for 1 additional client (#5), failed to ensure a physician prescribed diet order was accurate in a dysphagia plan, to update a fall plan as necessary and to include updated PT (physical therapy) recommendations to prevent recurrent falls for 1 additional client (#7).</p> <p>9-3-2(a)</p> <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 failed to develop and/or implement their abuse/neglect policy to prevent and ensure thorough investigation of an allegation of neglect in regards to elopement for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies to</p>	W000149	On 1/26/15 and 2/16/15 the Residential Manager and QDP were retrained on quality investigations, including thoroughness, investigating significant injuries, when a plan didn't work, peer to peer aggression, patterns or trends, abuse/neglect, unknown injuries, serious injuries, anything with potential to cause significant injury, and anything that is suspicious in nature. The QDP and RM were also retrained to	02/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506		
(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>prevent and investigate an allegation of neglect in regards to ingestion of a cleaning product for a client with a history of stealing food and fluids for 1 of 4 sampled clients (#2).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies and procedures to prevent recurrent falls and to investigate a fall which resulted in significant injury for 1 additional client (#5).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies and procedures to prevent recurrence of falls and to investigate a fall from an environmental hazard for 1 of 4 sampled clients (#1) and 1 additional client (#7).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies and procedures to prevent medical neglect in regards to ensuring fall plans were implemented as written, to update fall plans as necessary to prevent recurrence, to ensure fall plans were accurate and included updated PT (physical therapy) recommendations, to ensure fall plans included the use of a gait belt, to ensure fall plans clearly indicated level of</p>		<p>include the 'who, what, when, where and whys' of an investigation on the investigation document. (See attachment A - J &amp; ii-jj)</p> <p>On 2/16/15 the QDP and RM were trained that all allegations of abuse and neglect must be investigated immediately and the investigation needs to be completed within five working days. The IDT must meet to determine if an individual's plan needs updated and/or if staff need retrained. The IDT meeting will be documented used the IDT note form. (see attachment kk)</p> <p>The Director will monitor all investigations and IDT notes to ensure thorough documentation has occurred</p> <p>QDP, RM, and Director responsible</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>supervision required for clients requiring assistance for ambulation, to ensure dysphagia (swallowing disorder) risk plans had accurate physician prescribed diet orders and to ensure an accurate medical record keeping system to ensure accurate physician orders for diet and ambulation were uniformly documented for 2 of 4 sampled (#1, #2) and 2 additional clients (#5, #7).</p> <p>Findings include:</p> <p>1) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and the facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A BDDS report dated 9/3/14 indicated "... [Client #1] was sitting at his desk doing his puzzles. At 12:09pm staff received a phone call from a neighbor that spotted [Client #1] in [retail store] parking lot about a block away from the house. She had parked her car and went to [Client #1] and stayed with him until staff arrived. The neighbor stated that it was 12:05pm when she left her house two blocks from [retail store]." The BDDS report indicated "[Client #1] was assessed by staff when they returned home and no injuries were found. [Client #1] does have an AWOL (absent without leave)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>plan but has not gone AWOL in over two years." The report indicated "staff will be retrained on [Client #1]'s AWOL plan. Staff responsible will be disciplined according to [facility] policy."</p> <p>Client #1's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #1] also needs tracking because he will leave the group home without notifying staff. He has an Elopement Management Plan in place so staff can help [Client #1] with this behavior. [Client #1] must have one-on-one staff sight during waking hours." Client #1's ISP indicated "[Client #1] has intervention strategies in place to address his behavior of AWOL (absent without leave), and self-abuse." Client #1's ISP indicated "[Client #1] will go AWOL. Security door alarms in place and staff are not to let him out of their sight."</p> <p>Client #1's "Intervention strategies for [Client #1]" dated 7/2014 indicated an intervention for "Behaviors of AWOL". Client #1's intervention strategies indicated "I like to be outside when the weather is nice, I like to go outside to either sit or go for a walk. This should be encouraged because it is good for my health but I am unable to notice dangers while I am outside by myself; that is why I need staff assistance." Client #1's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>intervention strategies included the following:</p> <ol style="list-style-type: none"> <li>1. Staff should make sure that I get to go out on a walk at least once a day, weather permitting.</li> <li>2. Staff should inform me as we are walking that I need to have staff with me when I am going out for a walk.</li> <li>3. If I leave the building staff should get me back into the building and then after 5 minutes ask me if I would like to go outside for a walk.</li> <li>4. While staff is assisting me into the building they should tell me that I need to have staff with me when I want to go out for a walk.</li> <li>5. Staff should make sure that the door alarms are on to alert staff that I am leaving the building with out [sic] staff assistance."</li> </ol> <p>Record review indicated Client #1's "Risk Plan Compilation" indicated an "Elopement" plan. Client #1's Elopement risk plan dated 7/24/14 indicated "[Client #1] has a tendency to walk out of the group home and go for a walk when the weather is nice. [Client #1] will have an assigned staff that will keep him in eyesight during all waking hours." Client #1's "Elopement" risk plan indicated the following interventions:</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506		
(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>"* A staff member needs to be assigned to [Client #1] on all shifts during waking hours. This person has to have [Client #1] in eyesight at all times. Staff must sign in and sign off of [Client #1]. Be especially aware of [Client #1] during shift changes.</p> <p>* [Client #1] should go for walks 2x a day. Inside or outside, if the weather is bad you can take him to [name of store] to walk around.</p> <p>* If [Client #1] attempts elopement, he should not be taken on a walk. This will encourage his AWOL behavior.</p> <p>* [Client #1] has a goal to sign to staff, go, walk, and please. Encourage [Client #1] to use these signs when he wanted to communicate.</p> <p>*One staff will check the door alarm that has sounded, and make sure that [Client #1]'s whereabouts are accounted for. Staff that is assigned to [Client #1] needs to communicate that [Client #1] is present in the home after alarm."</p> <p>The investigation dated 9/8/14 was reviewed and indicated "At 12:09p (PM) [a neighbor] called and said she found [Client #1] near [phone service provider] (a block down the road)." The</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>investigation indicated no staff "signed on" to Client #1 to ensure his safety. The investigation indicated staff failed to monitor Client #1 as indicated in his elopement risk plan. The investigation did not document whether the door alarms were in working condition and there was no documentation that the staff were interviewed whether anyone heard the door alarm.</p> <p>During an interview on 1/23/15 at 2:05 PM, the House Manager (HM) indicated she was on personal leave during the incident. The HM stated the staff "might not" have been asked about the door alarm because in hot weather "with the humidity" the door "sticks and doesn't always shut all the way." The HM indicated if the door was not shut all the way, the magnetic door alarm would not have been activated. The HM indicated she agreed the door alarm should have been further investigated. The HM indicated staff was disciplined for negligence of job duties to ensure Client #1 was within eyesight to prevent elopement.</p> <p>2) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>10/27/14 to 1/20/15 were reviewed. A BDDS report dated 7/7/14 indicated "[Client #2] had finished his breakfast and was in the living room. [Client #3] was in the kitchen eating breakfast, [Client #2] came back in the kitchen and tried to drink [Client #3]'s juice. [Client #3] yelled and grabbed [Client #2]'s arm digging his finger nails into [Client #2]'s right arm. [Client #2] has three scratches about an inch and a half long on his right arm." The report indicated "staff will continue to follow [Client #2]'s behavior plan of food stealing by keeping an eye on him when he is in the kitchen."</p> <p>A follow up BDDS report indicated "[Client #2] is doing well and the scratches to his arm are healing. The IDT (interdisciplinary team) updated [Client #2]'s behavior plan to include that he needs to be within arm's reach of staff when he is in the kitchen when his peers are eating. [Client #2]'s behavior plan did address his attempts to steal others' food and stated that staff need to be in the kitchen with him, which staff followed, however, they were not able to intervene before his peer scratched him."</p> <p>A BDDS report dated 8/27/14 indicated "[Client #2] was helping staff1 clean up after supper. Staff2 was at the store. [Client #2] left the kitchen and went into</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 living room. Staff1 went into the restroom where there was an empty bottle of [cleaning product] under the sink. She questioned the other staff if they had it in the restroom, they said no. Staff looked further and found a drinking glass hidden under the sink with a little bit of blue liquid in the glass. Staff1 asked [Client #2] if he had the [cleaning product], he shook his head yes. Staff1 called poison control where they said to take him to the ER (emergency room). Staff1 took him to the [emergency room]. At the ER they did lab work to ensure that his electrolytes were in line." The report indicated "all lab work came back normal and no evidence of [Client #2] consuming any [cleaning product] was found." The report indicated "the IDT (interdisciplinary team) will meet to discuss the need of updating his plan and/or the need of locking cleaning supplies door so no further incident could occur."</p> <p>On 1/21/15 at 4:21 PM, record review indicated Client #2's diagnoses included, but were not limited to, severe intellectual disabilities, cerebral palsy, anxiety disorder, and ADHD (attention deficit hyperactivity disorder). Client #2's ISP (Individual Support Plan) dated 3/27/14 indicated "Yes, [Client #2] is prone to choking. He has a choking plan</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>in place for this, a cookie swallow was done." Client #2's ISP indicated "Yes staff track three behaviors for [Client #2]; skin picking, grabbing or stealing food, and AWOL (absence without leave)."</p> <p>Record review indicated Client #2 had a "Risk Plan Compilation" dated 3/27/14 which indicated (not all inclusive) a "Dysphagia" risk plan which indicated Client #2 "has a history of eating too fast and stealing food which is a choking risk." Client #2's plan indicated "if [Client #2] is standing while consuming food or beverages, it could cause him to choke. [Client #2] should remain seated in an upright position while consuming food or beverages." Client #2's plan indicated "[Client #2] does not swallow his food before taking another bite. [Client #2] tends to shovel his food in very rapidly and does not chew his food before he puts in more food." The plan indicated "[Client #2] likes to steal food. Staff needs to ensure when there is food left out it's monitored so that [Client #2] does not steal food. Staff needs to ensure if [Client #2] is in the kitchen a staff member is with him to prevent food stealing." The plan indicated "staff should monitor [Client #2] anytime he is in the kitchen to ensure he doesn't steal food."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>Record review indicated Client #2 had a BSP (behavior support plan) dated 3/2014 which indicated the targeted behaviors of SIB (self-injurious behavior), AWOL (absence without leave), grabbing (food items), intentional incontinence, non-compliance, and invading personal space. No documentation was available to indicate Client #2's BSP was updated after his attempt to steal juice from a client or drinking cleaning supplies.</p> <p>On 1/23/15 at 2:05 PM during an concurrent interview with the Administrator and the House Manager (HM), the Administrator indicated the incident of Client #2 potentially ingesting the cleaning product was not investigated. The Administrator indicated the cleaning products were not locked up because there was never a safety issue prior this incident. The Administrator indicated the cleaning products have been since locked and out of reach of clients. When asked whether Client #2 got the cleaning product while helping staff clean the kitchen as indicated in the BDDS (Bureau of Developmental Disabilities Services) report, the House Manager indicated she didn't think that particular cleaning product would have been out while cleaning the kitchen. The Administrator indicated no investigation</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>was completed to ensure staff were not negligent in monitoring the cleaning supplies but stated she could "understand why" it should have been completed.</p> <p>3) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A BDDS report dated 10/5/14 indicated "On 10-5-14 [Client #5] was drying off in the bathroom after his shower. [Client #5] lost his balance and fell backwards onto the wall and ending [sic] up sliding into the tub. [Client #5] has a 1/2 to 3/4 of an inch scratch on his upper left buttocks and possible bruising." The report indicated "[Client #5]'s team will continue to follow his fall plan to prevent future falls from taking place. If a pattern of falls develops [Client #5]'s team will meet to review his current fall plan."</p> <p>A BDDS report dated 10/8/14 indicated "staff was helping a consumer get out of bed when [Client #5] starting [sic] getting up by himself. Staff asked for him to wait a minute while she finished with the other consumer. Staff was on the left side of [Client #5], when [Client #5] got up on right side of his bed and started going towards the bathroom." The report</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506		
(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 "[Client #5] tripped over a chair in the room rushing to get to the bathroom. When [Client #5] fell, he hit his nose on the floor and it began bleeding. The staff followed precautions for universal Blood [sic] and body fluid by wearing gloves, cleaning area and disposal. The staff took him to the [emergency room] where the Doctor stopped the bleeding and said that [Client #5] [sic] nose was broken. He also stated that there was no reason to do an X-ray or reset the nose except for appearance." The report indicated "the chair was removed from his room. Staff will continue to follow his fall plan."</p> <p>A follow up BDDS report dated 10/14/14 indicated "[Client #5] is doing well. He has had no further issues with his nose. He has not complained of pain or indicated that his nose is bothering him." The report indicated "[Client #5] does not need to see his physician for any additional follow up. Staff continue to assist [Client #5] when he ambulates, as he tends to walk quickly."</p> <p>On 1/21/15 at 1:58 PM, record review indicated Client #5's diagnoses included, but were not limited to, profound intellectual disabilities, autism, severe organic dysfunction, and agitated behavior organic personality syndrome.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 #5's ISP (Individual Support Plan) dated 10/10/14 indicated Client #5 "needs assistance while ambulating. [Client #5] is unsteady when he first stands from a seated position. He has a Fall Management plan in place to include a gait belt so staff can help him steady himself before he ambulates." Client #5's ISP indicated "[Client #5] has injured himself in the past by moving too quickly, when he becomes agitated."</p> <p>Record review indicated Client #5 had a "Risk Plan Compilation" dated 10/10/14 which indicated a "Fall Management Plan". Client #5's fall plan indicated "has a history of getting up quickly and walking too fast which can cause falling." The plan indicated the following "interventions":</p> <p>"*Staff should walk with me when there is any type of terrain changes due to being unsteady from seizure medication.</p> <p>*Staff should be aware that I move quickly when getting out of seated position and initiating ambulating from place to place and be there for support and stability if I need it.</p> <p>*I utilize a shower chair due to general dizziness and poor balance. I use a shower chair to help me from falling in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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 shower. Staff will assist in washing and transferring in and out of my shower chair while showering."</p> <p>Client #5's fall plan indicated staff should monitor "terrain changes", "transferring to and from seated position", and "showering." Client #5's fall plan did not include the use of a gait belt.</p> <p>Record review indicated Client #5's physician's orders dated 1/1/15 indicated no order for a gait belt. Client #5's "Monthly Nurse's Notes" dated 10/2014 indicated "incident report 10/5/2014 r/t (resulted from) fall resulting in 1/2 inch scratch to upper left buttocks. Fall plan in place and followed." The notes indicated "10/08/2014 fall with injury/ER (emergency room) visit - broken nose (instructions noted: return to ER if recurrent nose bleed, no x-rays done). [Physician] suggested repair to nose would only be cosmetic and need referral to ENT (ear nose throat specialist). Fall plan in place and followed." Record review indicated Client #5 had a medication change on 10/15/14 by his neurologist. Record review indicated Client #5 had a neurology appointment on 1/15/15 which indicated "he has been more alert, better balance (sic) - less falls, staff seen (sic) a difference pretty quickly."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>Record review indicated Client #5 had a PT (physical therapy) appointment on 12/12/12 which indicated the recommendation "gait belt placement at hips or chest depending caregiver preference c (with) belt height, holding onto back of belt in center/midline."</p> <p>Record review indicated Client #5 had a PT appointment on 12/22/14 which indicated "continue current program."</p> <p>On 1/23/15 at 2:05 PM in a concurrent interview, the Administrator indicated no investigation was completed for Client #5's fall which resulted in a broken nose. The Administrator indicated Client #5 was getting out of bed while staff were assisting another client. The Administrator stated "staff told him to wait but he did not wait." When asked why staff did not immediately assist Client #5 when he began to get out of bed without staff assistance, the Administrator stated she did not know but "maybe staff were not at a good time to assist." The Administrator indicated Client #5's physician's orders did not include an order for the gait belt. The House Manager (HM) indicated Client #5 does use a gait belt in the home. The HM stated Client #5's use of gait belt was in "his original plan" but did not get transferred over to "the new compilation"</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>format. In regards to Client #5's fall in the bathroom on 10/5/14, the HM stated Client #5 "probably" did not have his gait belt on because staff said he was drying off and he would have been unclothed. The HM indicated Client #5 does use a shower chair but Client #5's fall plan did not indicate the level or type of supervision while drying off between the time he stands up from the shower chair to the time he has his gait belt on. The Administrator indicated no investigations were done on either of Client #5's falls. The HM indicated Client #5 had his medication changed to assist him with balance issues.</p> <p>4a) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A BDDS report dated 7/8/14 indicated "[Client #1] was walking from kitchen to living room and tripped over the carpet bar. He has a scrape on his forehead about an inch long from the carpet. Staff cleaned area and applied Bacitracin (antibacterial topical cream)." The report indicated "[Client #1] ambulates fairly well on flat surfaces. Staff will continue to encourage him to look where he is going to avoid obstacles according to his</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>fall plan."</p> <p>A BDDS report dated 10/23/14 indicated "[Client #1] was going on an outing. A staff was taking another consumer out to the van when [Client #1] came outside to get on the bus. He was behind a staff and another consumer when he became impatient and started to go around them. He went into the grass and tripped over a pumpkin that was in the grass. He scraped his chin and his left side of his face when he fell onto the driveway. Staff took him inside and cleaned up his scrape and applied Bacitracin (antibiotic cream topical)."</p> <p>A BDDS report dated 12/15/14 indicated "[Client #1] was coming out of the restroom when he tripped and fell into the wall then fell to the floor. Staff assisted him and asset [sic] for injuries. [Client #1] has an one inch scrape on his forehead on the left side and a half inch cut under his right arm." The report indicated "[Client #1] has a fall plan and staff followed the plan."</p> <p>An internal incident report dated 12/24/14 indicated Client #1 fell in the kitchen because the "kitchen floor was wet from mopping and [Client #1] slipped and fell." The report indicated the "kitchen floor had been mopped and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 #1] walked on wet floor and slipped." The incident report indicated "yes" to the question "Were there any environmental hazards that contributed to this accident?" The report indicated the hazard was "water on floor."</p> <p>On 1/21/15 at 4:55 PM, record review indicated Client #1's diagnoses included, but were not limited to, profound intellectual disabilities, Down's Syndrome, visual impairment, bilateral hearing loss, and Parkinson's disease. Client #1's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #1] is visually impaired, but refuses to wear glasses." Client #1's ISP indicated "[Client #1] suffers from bilateral hearing loss, but would refuse to wear hearing aids."</p> <p>Record review indicated Client #1 had a "Risk Plan Compilation" dated 7/24/14 which indicated Client #1 had a "Falling" risk area. Client #1's fall risk plan indicated "[Client #1] ambulates fairly well on flat surfaces. Caution needs to be exercised when [Client #1] is walking on uneven group or stepping up on curbs." Client #1's fall plan interventions indicated the following:</p> <p>** Needs monitoring in large crowds as I tend to get confused and staff needs to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>stay close to me to assure me that I am safe.</p> <p>* Staff will stay with me and prompt me to slow my pace.</p> <p>* Staff should walk with me encouraging me to look where I am going to to avoid hazards or obstacles. Staff will prompt me if they see something in my way so I can avoid it.</p> <p>* Staff should fully assist me when I am getting on and off of the van, standing behind me supporting me as I go up the steps, and standing in front of me when I go down the steps.</p> <p>* If I am getting into someone's personal vehicle staff should help me keep the door open and help me get my legs into the car safely and that I (am) seated and buckled before closing the door."</p> <p>Client #1's fall risk plan indicated "Monitoring" which indicated "staff should make [Client #1] aware of changes in terrain or of environmental obstacles."</p> <p>On 1/20/15 at 3:51 PM during an interview, the Administrator indicated there were no investigations into Client #1's falls to ensure his fall care plan was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>followed. The Administrator indicated the facility Quality Assurance committee had Client #1's group home on their list for fall trends and excessive falls. The Administrator indicated environmental checklists are done regularly by the House Manager to ensure no environment fall risks. The Administrator indicated no investigation had been completed for Client #1's falls. In regards to Client #1's fall on 12/24/14 on the wet kitchen floor, the Administrator stated "staff should not be mopping" while the clients are still awake.</p> <p>On 1/23/15 at 2:05 PM during an interview, the House Manager (HM) stated Client #1's fall on 10/23/14 was because he wasn't "patient" and rushed forward and tripped over a pumpkin. The HM indicated Client #1 will walk quickly when impatient and not watch where he is going. The HM indicated there was no further indication any investigations were completed.</p> <p>4b) A BDDS report dated 6/29/14 indicated "staff was assisting [Client #7] to the bathroom. [Client #7] reached for the metal bar on the wall, missed it and fell over the (sic) forward hitting the toilet with arm and leg. Staff lowered him to the floor and checked for any serious injuries before getting him back up. Once</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>staff had him sitting, staff assessed him. [Client #7] has a scrape the size of a nickel on left elbow and just under that there is another scrape about 2 inches long. He has a bruise on inside of left thigh about 1 inch in diameter." The report indicated "Staff will continue to follow [Client #7]'s fall plan of walking beside him using his gait belt."</p> <p>A BDDS report dated 10/5/14 indicated "during the night of 10-4-14 [Client #7] was standing in his bedroom holding onto his dresser. [Client #7] lost his balance/strength in his arms and fell forward into the dresser and then down to the floor. [Client #7]'s face was red but no other injuries were found at the time of accident. On the morning of 10-5-14 staff checked [Client #7] and found his right cheek was still red and slightly swollen." The report indicated "staff will assist [Client #7] while he is standing to help prevent future falls. Staff will continue to monitor [Client #7] to ensure he is not showing any signs of concussion."</p> <p>A BDDS report dated 10/19/14 indicated "during the day of 10-18-14 [Client #7] was walking with staff when he stumbled and fell to the ground. Staff held him by his gait belt and let him down to the ground. No injuries were found at the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>time of the fall. However, during the morning of 10-19-14 staff found a carpet rash on [Client #7]'s forehead by his hair line. The rash is about the size of a quarter." The report indicated "[Client #7] became excited due to being close to his chair and the excitement cause [sic] [Client #7] to fall forward. Staff followed [Client #7]'s fall risk plan by utilizing [Client #7]'s gait belt while he was ambulating. Staff assisted [Client #7] to the ground when he began to show signs of falling."</p> <p>On 1/21/15 at 2:03 PM, record review indicated Client #7's diagnoses, included but were not limited to, profound intellectual disabilities, OCD (obsessive compulsive disorder), organic personality disorder, probable seizures, and Parkinson's disease. Client #7's physician's order dated 1/1/15 indicated "staff to use gait belt to assist with ambulation."</p> <p>Record review indicated Client #7's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #7] has some difficulty getting up from his favorite chair, staff should not pull him up, but encourage him to get up on his own, with an assistive device, if necessary. Client #7's ISP indicated a "Risk Plan Compilation" dated 7/24/14 which did not indicate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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 #7 had a current fall risk plan or indication for gait belt use.</p> <p>Record review indicated Client #7 had an PT (physical therapy) appointment on 10/17/13 which indicated "gait belt to assist with ambulation." Record review indicated Client #7 had a PT appointment dated 12/31/14 which indicated the recommendation "continue assist c (with) 2 (staff) and continue yearly eval (evaluation)."</p> <p>On 1/23/15 at 2:05 PM during a concurrent interview, the Administrator indicated there were no investigations completed for Client #7's falls. The Administrator stated the House Manager (HM) usually ensures fall plans were followed and they assess the environment routinely for fall hazards "but, no" there were no formal investigations completed. The Administrator indicated falls and trends of falls are monitored by the facility's Quality Assurance Committee. The Administrator stated she "can understand" why trends of falls would need to be investigated to ensure care plans were being implemented correctly. The HM indicated Client #7's "Risk Plan Compilation" in the record book in the office was an incorrect version. The HM stated Client #7's current fall risk plan indicated "staff will assist" but did not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>indicate how many staff. The HM indicated the fall risk plan was not updated to include the 12/31/14 PT (physical therapist) recommendation for Client #7 to ambulate with 2 staff assist with use of gait belt.</p> <p>6) Please see W331. The facility nursing staff failed to ensure a fall plan was implemented as written to prevent recurrence of falls for 1 of 4 sampled clients (#1), failed to ensure a physician prescribed diet order was accurate in a dysphagia (swallowing disorder) plan in the client record book for 1 of 4 sampled clients (#2), failed to ensure a fall care plan was implemented as written, was revised as necessary to prevent recurrence of falls, and failed to include the use of a gait belt in client's fall risk plan for 1 additional client (#5), failed to ensure physician prescribed diet order was accurate in a dysphagia plan, to update fall plan as necessary and to include updated PT (physical therapy) recommendations to prevent recurrent falls for 1 additional client (#7).</p> <p>On 1/23/15 at 3:25 PM the facility "Incident/Abuse/Neglect Policy" dated 5/13 indicated the facility "is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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
W000153	<p>neglect, or exploitation of persons served by staff members, or other persons served, or others will not be tolerated...".</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to report to the state agency (Bureau of Developmental Disabilities Services) an allegation of neglect in regards to a fall due to an accident hazard (wet floor) for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. An internal incident report dated 12/24/14 indicated Client #1 fell in the kitchen</p>	W000153	<p>On 2/16/15 DSPs were retrained on the agency's Incident/Abuse/Neglect Policy. (See attachment II – mm and K-R). To ensure DSPs are recognizing the differences between an internal accident report and a BDDS incident report, employees are quizzed on the differences between reportable incidents during observations. Additionally, the RM and QDP have been retrained to check the internal accident reports daily to ensure staff reported accurately. In the event staff fail to identify an incident correctly, immediate retraining will occur. The QDP and Manager will monitor reports daily and quiz staff during weekly observations. RM and QDP responsible</p>	02/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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			
W000154	<p>because the "kitchen floor was wet from mopping and [Client #1] slipped and fell." The report indicated the "kitchen floor had been mopped and [Client #1] walked on wet floor and slipped." The incident report indicated "yes" to the question "Were there any environmental hazards that contributed to this accident?" The report indicated the hazard was "water on floor."</p> <p>On 1/20/15 at 3:51 PM during an interview, the Administrator indicated in regards to Client #1's fall on 12/24/14 on the wet kitchen floor, the Administrator stated "staff should not be mopping" while the clients are still awake. The Administrator indicated no BDDS (Bureau of Developmental Disabilities) report was filed.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506		
(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>investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of neglect in regards of an elopement for 1 of 4 sample clients (#1).</p> <p>Based on record review, interview, and observation, the facility failed to thoroughly investigate an allegation of neglect in regards to a fall caused by an accident hazard (wet floor) for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of neglect in regards to ingestion of a cleaning product for 1 of 4 sampled clients (#2).</p> <p>Based on record review and interview, the facility failed to thoroughly investigate falls with significant injury (broken nose) and/or the potential for significant injury (fall into the bathtub) for 1 additional client (#5).</p> <p>Findings include:</p> <p>1) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal</p>	W000154	<p>On 1/26/15 and 2/16/15 the Residential Manager and QDP were retrained on quality investigations, including thoroughness, investigating significant injuries, when a plan didn't work, peer to peer aggression, patterns or trends, abuse/neglect, unknown injuries, serious injuries, anything with potential to cause significant injury, and anything that is suspicious in nature. The QDP and RM were also retrained to include the 'who, what, when, where and whys' of an investigation on the investigation document. (See attachment A - J &amp; ii-jj) On 2/16/15 the QDP and RM were trained that all allegations of abuse and neglect must be investigated immediately and the investigation needs to be completed within five working days. The IDT must meet to determine if an individual's plan needs updated and/or if staff need retrained. The IDT meeting will be documented used the IDT note form. (see attachment kk) The Director will monitor all investigations and IDT notes to ensure thorough documentation has occurred.</p> <p>QDP, RM, and Director responsible</p>	02/26/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A BDDS report dated 9/3/14 indicated "Approximately [Client #1] was sitting at his desk doing his puzzles. At 12:09pm staff received a phone call from a neighbor that spotted [Client #1] in [retail store] parking lot about a block away from the house. She had parked her car and went to [Client #1] and stayed with him until staff arrived. The neighbor stated that it was 12:05pm when she left her house two blocks from [retail store]." The BDDS report indicated "[Client #1] was assessed by staff when they returned home and no injuries were found. [Client #1] does have an AWOL (absent without leave) plan but has not gone AWOL in over two years." The report indicated "staff will be retrained on [Client#1]'s AWOL plan. Staff responsible will be disciplined according to [facility] policy."</p> <p>Client #1's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #1] also needs tracking because he will leave the group home without notifying staff. He has an Elopement Management Plan in place so staff can help [Client #1] with this behavior. [Client #1] must have one-on-one staff sight during waking hours." Client #1's ISP indicated "[Client #1] has intervention strategies in place to address his behavior of AWOL (absent</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>without leave), and self-abuse." Client #1's ISP indicated "[Client #1] will go AWOL. Security door alarms in place and staff are not to let him out of their sight."</p> <p>Client #1's "Intervention strategies for [Client #1]" dated 7/2014 indicated an intervention for "Behaviors of AWOL". Client #1's intervention strategies indicated "I like to be outside when the weather is nice, I like to go outside to either sit or go for a walk. This should be encouraged because it is good for my health but I am unable to notice dangers while I am outside by myself; that is why I need staff assistance." Client #1's intervention strategies included the following:</p> <ol style="list-style-type: none"> <li>1. Staff should make sure that I get to go out on a walk at least once a day, weather permitting.</li> <li>2. Staff should inform me as we are walking that I need to have staff with me when I am going out for a walk.</li> <li>3. If I leave the building staff should get me back into the building and then after 5 minutes ask me if I would like to go outside for a walk.</li> <li>4. While staff is assisting me into the building they should tell me that I need to have staff with me when I want to go out for a walk.</li> </ol>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>5. Staff should make sure that the door alarms are on to alert staff that I am leaving the building with out [sic] staff assistance."</p> <p>Record review indicated Client #1's "Risk Plan Compilation" indicated an "Elopement" plan. Client #1's Elopement risk plan dated 7/24/14 indicated "[Client #1] has a tendency to walk out of the group home and go for a walk when the weather is nice. [Client #1] will have an assigned staff that will keep him in eyesight during all waking hours." Client #1's "Elopement" risk plan indicated the following interventions:</p> <p>"* A staff member needs to be assigned to [Client #1] on all shifts during waking hours. This person has to have [Client #1] in eyesight at all times. Staff must sign in and sign off of [Client #1]. Be especially aware of [Client #1] during shift changes.</p> <p>* [Client #1] should go for walks 2x a day. Inside or outside, if the weather is bad you can take him to [name of store] to walk around.</p> <p>* If [Client #1] attempts elopement, he should not be taken on a walk. This will encourage his AWOL behavior.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 #1] has a goal to sign to staff, go, walk, and please. Encourage [Client #1] to use these signs when he wanted to communicate.</p> <p>*One staff will check the door alarm that has sounded, and make sure that [Client #1]'s whereabouts are accounted for. Staff that is assigned to [Client #1] needs to communicate that [Client #1] is present in the home after alarm."</p> <p>The investigation dated 9/8/14 was reviewed and indicated "At 12:09p (PM) [a neighbor] called and said she found [Client #1] near [phone service provider] (a block down the road)." The investigation indicated no staff "signed on" to Client #1 to ensure his safety. The investigation indicated staff failed to monitor Client #1 as indicated in his elopement risk plan. The investigation did not document whether the door alarms were in working condition and there was no documentation that the staff were interviewed whether anyone heard the door alarm.</p> <p>During an interview on 1/23/15 at 2:05 PM, the House Manager (HM) indicated she was on personal leave during the incident. The HM stated the staff "might not" have been asked about the door alarm because in hot weather "with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>humidity" the door "sticks and doesn't always shut all the way." The HM indicated if the door was not shut all the way, the magnetic door alarm would not have been activated. The HM indicated she agreed the door alarm should have been further investigated. The HM indicated staff was disciplined for negligence of job duties to ensure Client #1 was within eyesight to prevent elopement.</p> <p>2) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. An internal incident report dated 12/24/14 indicated Client #1 fell in the kitchen because the "kitchen floor was wet from mopping and [Client #1] slipped and fell." The report indicated the "kitchen floor had been mopped and [Client #1] walked on wet floor and slipped." The incident report indicated "yes" to the question "Were there any environmental hazards that contributed to this accident?" The report indicated the hazard was "water on floor."</p> <p>On 1/21/15 at 4:55 PM, record review indicated Client #1's diagnoses included, but were not limited to, profound</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>intellectual disabilities, Down's Syndrome, visual impairment, bilateral hearing loss, and Parkinson's disease. Client #1's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #1] is visually impaired, but refuses to wear glasses." Client #1's ISP indicated "[Client #1] suffers from bilateral hearing loss, but would refuse to wear hearing aids."</p> <p>Record review indicated Client #1's had a "Risk Plan Compilation" dated 7/24/14 which indicated Client #1 had a "Falling" risk area. Client #1's fall risk plan indicated "[Client #1] ambulates fairly well on flat surfaces. Caution needs to be exercised when [Client #1] is walking on uneven group or stepping up on curbs."</p> <p>On 1/20/15 at 3:51 PM during an interview, the Administrator indicated an investigation was not completed for Client #1's fall on the wet floor. The Administrator indicated environmental checklists are done regularly by the House Manager to ensure no environment fall risks. In regards to Client #1's fall on 12/24/14 on the wet kitchen floor, the Administrator stated "staff should not be mopping" while the clients are still awake.</p> <p>3) A BDDS report dated 8/27/14</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 "[Client #2] was helping staff1 clean up after supper. Staff2 was at the store. [Client #2] left the kitchen and went into the living room. Staff1 went into the restroom where she was an empty bottle of [cleaning product] under the sink. She questioned the other staff if they had it in the restroom, they said no. Staff looked further and found a drinking glass hidden under the sink with a little bit of blue liquid in the glass. Staff1 asked [Client #2] if he had the [cleaning product] he shook his head yes. Staff1 called poison control where they said to take him to the ER (emergency room). Staff1 took him to the [emergency room]. At the ER they did lab work to ensure that his electrolytes were in line." The report indicated "all lab work came back normal and no evidence of [Client #2] consuming any [cleaning product] was found." The report indicated "the IDT (interdisciplinary team) will meet to discuss the need of updating his plan and/or the need of locking cleaning supplies door so no further incident could occur."</p> <p>On 1/21/15 at 4:21 PM, record review indicated Client #2's diagnoses included, but were not limited to, severe intellectual disabilities, cerebral palsy, anxiety disorder, and ADHD (attention deficit hyperactivity disorder). Client #2's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>ISP (Individual Support Plan) dated 3/27/14 indicated "Yes, [Client #2] is prone to choking. He has a choking plan in place for this, a cookie swallow was done." Client #2's ISP indicated "Yes staff track three behaviors for [Client #2]; skin picking, grabbing or stealing food, and AWOL (absence without leave)."</p> <p>Record review indicated Client #2 had a "Risk Plan Compilation" dated 3/27/14 which indicated (not all inclusive) a "Dysphagia" risk plan indicated Client #2 "has a history of eating too fast and stealing food which is a choking risk." Client #2's plan indicated "if [Client #2] is standing while consuming food or beverages, it could cause him to choke. [Client #2] should remain seated in an upright position while consuming food or beverages."</p> <p>On 1/23/15 at 2:05 PM during an concurrent interview with the Administrator and the House Manager HM, the Administrator indicated the incident of Client #2 ingesting the cleaning product was not investigated. The Administrator indicated the cleaning products were not locked up because there was never a safety issue prior to this incident. The Administrator indicated the cleaning products have been since locked and are out of reach of clients. When</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506		
(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>asked whether Client #2 got the cleaning product while helping staff clean the kitchen as indicated in the BDDS (Bureau of Developmental Disabilities Services) report, the House Manager indicated she didn't think that particular cleaning product would have been out while cleaning the kitchen. The Administrator indicated no investigation was completed to ensure staff were not negligent in monitoring the cleaning supplies but stated she could "understand why" it should have been completed.</p> <p>4) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A BDDS report dated 10/5/14 indicated "On 10-5-14 [Client #5] was drying off in the bathroom after his shower. [Client #5] lost his balance and fell backwards onto the wall and ending [sic] up sliding into the tub. [Client #5] has a 1/2 to 3/4 of an inch scratch on his upper left buttocks and possible bruising." The report indicated "[Client #5]'s team will continue to follow his fall plan to prevent future falls from taking place. If a pattern of falls develops [Client #5]'s team will meet to review his current fall plan."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>A BDDS report dated 10/8/14 indicated "staff was helping a consumer get out of bed when [Client #5] starting [sic] getting up by himself. Staff asked for him to wait a minute while she finished with the other consumer. Staff was on the left side of [Client #5], when [Client #5] got up on right side of his bed and started going towards the bathroom." The report indicated "[Client #5] tripped over a chair in the room rushing to get to the bathroom. When [Client #5] fell, he hit his nose on the floor and it began bleeding. The staff followed precautions for universal Blood [sic] and body fluid by wearing gloves, cleaning area and disposal. The staff took him to the [emergency room] where the Doctor stopped the bleeding and said that [Client #5] [sic] nose was broken. He also stated that there was no reason to do an X-ray or reset the nose except for appearance." The report indicated "the chair was removed from his room. Staff will continue to follow his fall plan."</p> <p>A follow up BDDS report dated 10/14/14 indicated "[Client #5] is doing well. He has had no further issues with his nose. He has not complained of pain or indicated that his nose is bothering him." The report indicated "[Client #5] does not need to see his physician for any additional follow up. Staff continue to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>assist [Client #5] when he ambulates, as he tends to walk quickly."</p> <p>On 1/21/15 at 1:58 PM, record review indicated Client #5's diagnoses included, but were not limited to, profound intellectual disabilities, autism, severe organic dysfunction, and agitated behavior organic personality syndrome. Client #5's ISP (Individual Support Plan) dated 10/10/14 indicated Client #5 "needs assistance while ambulating. [Client #5] is unsteady when he first stands from a seated position. He has a Fall Management plan in place to include a gait belt so staff can help him steady himself before he ambulates." Client #5's ISP indicated "[Client #5] has injured himself in the past by moving too quickly, when he becomes agitated."</p> <p>Record review indicated Client #5 had a "Risk Plan Compilation" dated 10/10/14 which indicated a "Fall Management Plan". Client #5's fall plan indicated "has a history of getting up quickly and walking too fast which can cause falling." Record review indicated Client #5's physician's orders dated 1/1/15 included no order for gait belt. Client #5's "Monthly Nurse's Notes" dated 10/2014 indicated "incident report 10/5/2014 r/t (resulted from) fall resulting in 1/2 inch scratch to upper left buttocks. Fall plan in</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>place and followed." The notes indicated "10/08/2014 fall with injury/ER (emergency room) visit - broken nose (instructions noted: return to ER if recurrent nose bleed, no x-rays done). [Physician] suggested repair to nose would only be cosmetic and need referral to ENT (ear nose throat specialist). Fall plan in place and followed." Record review indicated Client #5 had a medication change on 10/15/14 by his neurologist. Record review indicated Client #5 had a neurology appointment on 1/15/15 which indicated "he has been more alert, better balance (sic) - less falls, staff seen (sic) a difference pretty quickly."</p> <p>On 1/23/15 at 2:05 PM in a concurrent interview, the Administrator indicated no investigation was completed for Client #5's falls. The Administrator indicated when Client #5 broke his nose, he was getting out of bed while staff were assisting another client. The Administrator stated "staff told him to wait but he did not wait." When asked why staff did not immediately assist Client #5 when he began to get out of bed without staff assistance, the Administrator stated she did not know but "maybe staff were not at a good time to assist." In regards to Client #5's fall in the bathroom on 10/5/14, the HM stated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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
W000157	<p>Client #5 "probably" was not wearing his gait belt because staff said he was drying off and he would have been unclothed. The HM indicated Client #5 does use a shower chair but indicated Client #5's fall plan did not indicate level or type of supervision while drying off between the time he stands up from the shower chair to the time he has his gait belt on. The Administrator indicated no investigations were done on either of Client #5's falls.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review, and interview, the facility failed to implement sufficient corrective action in regards to a fall due to an accident hazard (wet floor) caused by staff mopping for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>On 1/15/15 between 4:38 PM and 6:32 PM, group home observations were conducted. After dinner, staff mopped the kitchen floor while Client #6 and Client #7 were still at the dining room table. At</p>	W000157	<p>On 2/16/15 the RM, QDP, and DSPs weretrained on a new mopping protocol for the home. (See attachment nn - oo) Staff are still supposed to ensure consumers to participate in allhousehold activities when appropriate. Staff were also trained to ensure a safe environment. Individuals who wish to mop can do so afterthose who do not recognize the dangers of a wet floor and/or have a fall riskplan no longer need the use of the kitchen. Staff will also take additional measures to ensure the floor driesquickly in event of a spill or other environmental hazard occurs while the kitchenis</p>	02/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>6:18 PM, Client #4 approached the kitchen and placed one foot on the wet kitchen floor before he noticed the wet floor and turned around. Staff did not redirect Client #4 not to walk on the wet floor.</p> <p>On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. An internal incident report dated 12/24/14 indicated Client #1 fell in the kitchen because the "kitchen floor was wet from mopping and [Client #1] slipped and fell." The report indicated the "kitchen floor had been mopped and [Client #1] walked on wet floor and slipped." The incident report indicated "yes" to the question "Were there any environmental hazards that contributed to this accident?" The report indicated the hazard was "water on floor."</p> <p>On 1/21/15 at 4:55 PM, record review indicated Client #1's diagnoses included, but were not limited to, profound intellectual disabilities, Down's Syndrome, visual impairment, bilateral hearing loss, and Parkinson's disease. Client #1's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #1] is</p>		<p>still in use. To ensure this deficiency does not occur again, the RM and QDP will monitor compliance through weekly observations. RM and QDP responsible</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506		
(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>visually impaired, but refuses to wear glasses." Client #1's ISP indicated "[Client #1] suffers from bilateral hearing loss, but would refuse to wear hearing aids."</p> <p>Record review indicated Client #1's had a "Risk Plan Compilation" dated 7/24/14 which indicated Client #1 had a "Falling" risk area. Client #1's fall risk plan indicated "[Client #1] ambulates fairly well on flat surfaces. Caution needs to be exercised when [Client #1] is walking on uneven group or stepping up on curbs." Client #1's fall plan interventions indicated the following:</p> <p>"* Needs monitoring in large crowds as I tend to get confused and staff needs to stay close to me to assure me that I am safe.</p> <p>* Staff will stay with me and prompt me to slow my pace.</p> <p>* Staff should walk with me encouraging me to look where I am going to to avoid hazards or obstacles. Staff will prompt me if they see something in my way so I can avoid it.</p> <p>* Staff should fully assist me when I am getting on and off of the van, standing behind me supporting me as I go up the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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
W000227	<p>steps, and standing in front of me when I go down the steps.</p> <p>* If I am getting into someone's personal vehicle staff should help me keep the door open and help me get my legs into the car safely and that I (am) seated and buckled before closing the door."</p> <p>Client #1's fall risk plan indicated "Monitoring" which indicated "staff should make [Client #1] aware of changes in terrain or of environmental obstacles."</p> <p>On 1/20/15 at 3:51 PM during an interview, the Administrator indicated environmental checklists are done regularly by the House Manager to ensure no environment fall risks. In regards to Client #1's fall on 12/24/14 on the wet kitchen floor, the Administrator stated "staff should not be mopping" while the clients are still awake. The House Manager indicated no further corrective action was taken to ensure floors remained dry during the client's waking hours.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 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.</p> <p>Based on record review and interview, the facility failed to ensure a client's BSP (behavior support plan) included the stealing of liquids and the potential to ingest hazardous material for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A BDDS report dated 7/7/14 indicated "[Client #2] had finished his breakfast and was in the living room. [Client #3] was in the kitchen eating breakfast, [Client #2] came back in the kitchen and tried to drink [Client #3]'s juice. [Client #3] yelled and grabbed [Client #2]'s arm digging his finger nails into [Client #2]'s right arm. [Client #2] has three scratches about an inch and a half long on his right arm." The report indicated "staff will continue to follow [Client #2]'s behavior plan of food stealing by keeping an eye on him when he is in the kitchen."</p>	W000227	<p>On 1/27/15 the QDP revised client #2's BMP to include the behavior of stealing liquids and the possible ingestion of a cleaning product. Staff were trained on the updated behavior plan on 2/17/15. (see attachments pp-zz) Staff were also trained on client #2's updated choking plan, which now includes the theft of liquids. (See attachment aaa-ccc) On 2/16/15 the QDP, RM, and nurse were trained on when to update a risk and/or behavior plans and that all changes must be trained to staff immediately. (See attachment ddd)</p> <p>To ensure this deficiency does not occur in the future, the Director will review all IDT notes and investigations to ensure proper follow through occurs. QDP, RM, Nurse, Director responsible</p>	02/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>A follow up BDDS report indicated "[Client #2] is doing well and the scratches to his arm are healing. The IDT (interdisciplinary team) updated [Client #2]'s behavior plan to include that he needs to be within arm's reach of staff when he is in the kitchen when his peers are eating. [Client #2]'s behavior plan did address his attempts to steal others' food and stated that staff need to be in the kitchen with him, which staff followed, however, they were not able to intervene before his peer scratched him."</p> <p>A BDDS report dated 8/27/14 indicated "[Client #2] was helping staff1 clean up after supper. Staff2 was at the store. [Client #2] left the kitchen and went into the living room. Staff1 went into the restroom where she was an empty bottle of [cleaning product] under the sink. She questioned the other staff if they had it in the restroom, they said no. Staff looked further and found a drinking glass hidden under the sink with a little bit of blue liquid in the glass. Staff1 asked [Client #2] if he had the [cleaning product] he shook his head yes. Staff1 called poison control where they said to take him to the ER (emergency room). Staff1 took him to the [emergency room]. At the ER they did lab work to ensure that his electrolytes were in line." The report</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 "all lab work came back normal and no evidence of [Client #2] consuming any [cleaning product] was found." The report indicated "the IDT (interdisciplinary team) will meet to discuss the need of updating his plan and/or the need of locking cleaning supplies door so no further incident could occur."</p> <p>On 1/21/15 at 4:21 PM, record review indicated Client #2's diagnoses included, but were not limited to, severe intellectual disabilities, cerebral palsy, anxiety disorder, and ADHD (attention deficit hyperactivity disorder). Client #2's ISP (Individual Support Plan) dated 3/27/14 indicated "Yes, [Client #2] is prone to choking. He has a choking plan in place for this, a cookie swallow was done." Client #2's ISP indicated "Yes staff tracks three behaviors for [Client #2]; skin picking, grabbing or stealing food, and AWOL (absence without leave)."</p> <p>Record review indicated Client #2 had a "Risk Plan Compilation" dated 3/27/14 which indicated (not all inclusive) a "Dysphagia" risk plan. Client #2's has a history of eating too fast and stealing food which is a choking risk." Client #2's plan indicated "if [Client #2] is standing while consuming food or beverages, it</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>could cause him to choke. [Client #2] should remain seated in an upright position while consuming food or beverages." Client #2's plan indicated "[Client #2] does not swallow his food before taking another bite. [Client #2] tends to shovel his food in very rapidly and does not chew his food before he puts in more food." The plan indicated "[Client #2] likes to steal food. Staff needs to ensure when there is food left out is monitored so that [Client #2] does not steal food. Staff needs to ensure if [Client #2] is in the kitchen a staff member is with him to prevent food stealing." The plan indicated "staff should monitor [Client #2] anytime he is in the kitchen to ensure he doesn't steal food."</p> <p>Record review indicated Client #2 had a BSP (behavior support plan) dated 3/2014 which indicated the targeted behaviors of SIB (self-injurious behavior), AWOL (absence without leave), grabbing (food items), intentional incontinence, non-compliance, and invading personal space. No documentation was available to indicate Client #2's BSP was updated after his attempt to steal juice from a client and no indication Client #2's BSP was updated to include the potential for Client #2 to ingest hazardous materials.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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
W000331	<p>On 1/23/15 at 2:05 PM during an concurrent interview with the Administrator and the House Manager (HM), the Administrator indicated the cleaning products were not locked up because there was never a safety issue prior that incident. The Administrator indicated the cleaning products have been since locked and out of reach of clients. The Administrator indicated there was no further documentation to indicate Client #2's BSP had been updated to include ingestion of chemical/hazardous materials.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review, the facility nursing staff failed to ensure a fall plan was implemented as written to prevent recurrence of falls for 1 of 4 sampled clients (#1).</p> <p>Based on interview and record review, the facility nursing staff failed to ensure a physician prescribed diet order was accurate in a dysphagia (swallowing</p>	W000331	<p>On 2/16/15 the RM, Nurse, and QDP were retrained on the change in protocol for updating plans, which includes all medically prescribed changes / new diagnoses (OT/PT/Physician/Nutritionist, etc.) will require IDT oversight to ensure updates occur and staff are trained as prescribed. Additionally any new or updated change to an individual's plan requires additional staff oversight until staff can demonstrate competency with the</p>	02/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>disorder) plan in the client record book for 1 of 4 sampled clients (#2).</p> <p>Based on interview and record review, the facility nursing staff failed to ensure fall care plan was implemented as written, was revised as necessary to prevent recurrence of falls, and failed to include the use of a gait belt in client's fall risk plan for 1 additional client (#5).</p> <p>Based on interview and record review, the facility nursing staff failed to ensure a physician prescribed diet order was accurate in a dysphagia plan, to update a fall plan as necessary and to include updated PT (physical therapy) recommendations to prevent recurrent falls for 1 additional client (#7).</p> <p>Findings include:</p> <p>1) On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A BDDS report dated 7/8/14 indicated "[Client #1] was walking from kitchen to living room and tripped over the carpet bar. He has a scrape on his forehead about an inch long from the carpet. Staff cleaned area and applied Bacitracin</p>		<p>plan. Additional staff oversight includes an observation by the RM, QDP, Nurse, or Director. (See attachment eee)</p> <p>Client #2's dysphagia plan is current in both the home and office files. Client #5's fall risk plan was updated and trained to agency staff (See attachments U-Y).</p> <p>Client # 7's fall risk plan was updated to include PT's new recommendation. This update was trained to staff. (See attachments Z - cc).</p> <p>Client #1's fall risk plan was reviewed and retrained to agency staff between 2/11/15-2/17/15. (See attachments fff-iii)</p> <p>To ensure these deficiencies do not occur again, the agency updated the protocol to ensure additional oversight when the nurse and QDP are updating plan. This is an ongoing monitoring change. The QDP, Nurse, RM, or Director are responsible to increase observations when a new plan is implemented or updated to ensure staff competency. Once competency is demonstrated on all shifts, the observations schedule can resume as normal.</p> <p>QDP, Nurse, RM, and Director responsible</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>(antibacterial topical cream)." The report indicated "[Client #1] ambulates fairly well on flat surfaces. Staff will continue to encourage him to look where he is going to avoid obstacles according to his fall plan."</p> <p>A BDDS report dated 10/23/14 indicated "[Client #1] was going on an outing. A staff was taking another consumer out to the van when [Client #1] came outside to get on the bus. He was behind a staff and another consumer when he became impatient and started to go around them. He went into the grass and tripped over a pumpkin that was in the grass. He scraped his chin and his left side of his face when he fell onto the driveway. Staff took him inside and cleaned up his scrape and applied Bacitracin (antibiotic cream topical)."</p> <p>A BDDS report dated 12/15/14 indicated "[Client #1] was coming out of the restroom when he tripped and fell into the wall then fell to the floor. Staff assisted him and asset [sic] for injuries. [Client #1] has an one inch scrape on his forehead on the left side and a half inch cut under his right arm." The report indicated "[Client #1] has a fall plan and staff followed the plan."</p> <p>An internal incident report dated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>12/24/14 indicated Client #1 fell in the kitchen because the "kitchen floor was wet from mopping and [Client #1] slipped and fell." The report indicated the "kitchen floor had been mopped and [Client #1] walked on wet floor and slipped." The incident report indicated "yes" to the question "Were there any environmental hazards that contributed to this accident?" The report indicated the hazard was "water on floor."</p> <p>On 1/21/15 at 4:55 PM, record review indicated Client #1's diagnoses included, but were not limited to, profound intellectual disabilities, Down's Syndrome, visual impairment, bilateral hearing loss, and Parkinson's disease. Client #1's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #1] is visually impaired, but refuses to wear glasses." Client #1's ISP indicated "[Client #1] suffers from bilateral hearing loss, but would refuse to wear hearing aids."</p> <p>Record review indicated Client #1's had a "Risk Plan Compilation" dated 7/24/14 which indicated Client #1 had a "Falling" risk area. Client #1's fall risk plan indicated "[Client #1] ambulates fairly well on flat surfaces. Caution needs to be exercised when [Client #1] is walking on uneven group or stepping up on curbs."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 #1's fall plan interventions indicated the following:</p> <p>"* Needs monitoring in large crowds as I tend to get confused and staff needs to stay close to me to assure me that I am safe.</p> <p>* Staff will stay with me and prompt me to slow my pace.</p> <p>* Staff should walk with me encouraging me to look where I am going to to avoid hazards or obstacles. Staff will prompt me if they see something in my way so I can avoid it.</p> <p>* Staff should fully assist me when I am getting on and off of the van, standing behind me supporting me as I go up the steps, and standing in front of me when I go down the steps.</p> <p>* If I am getting into someone's personal vehicle staff should help me keep the door open and help me get my legs into the car safely and that I (am) seated and buckled before closing the door."</p> <p>Client #1's fall risk plan indicated "Monitoring" which indicated "staff should make [Client #1] aware of changes in terrain or of environmental obstacles."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>On 1/20/15 at 3:51 PM during an interview, the Administrator indicated there were no investigations into Client #1's falls to ensure his fall care plan was followed. The Administrator indicated the facility Quality Assurance committee had Client #1's group home on their list for fall trends and excessive falls. The Administrator indicated environmental checklists are done regularly by the House Manager to ensure no accident/hazard fall risks. The Administrator indicated both the group home nurse and QIDP (Qualified Intellectual Disabilities Professional) were new to their positions. The Administrator indicated there was no documentation to indicate Client #1's fall risk plan was updated to prevent further recurrence of falls.</p> <p>On 1/23/15 at 2:05 PM during an interview, the House Manager (HM) stated Client #1's fall on 10/23/14 was because he wasn't "patient" and rushed forward and tripped over a pumpkin. The HM indicated Client #1 will walk quickly when impatient and not watch where he is going. The HM indicated there was no further indication any investigations were completed.</p> <p>2) On 1/21/15 at 4:21 PM, record review</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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 Client #2's diagnoses included, but were not limited to, severe intellectual disabilities, cerebral palsy, anxiety disorder, and ADHD (attention deficit hyperactivity disorder). Client #2's ISP (Individual Support Plan) dated 3/27/14 indicated Client #2 had a "Risk Plan Compilation" which indicated (not all inclusive) a "Dysphagia" risk plan which indicated Client #2 "has a history of eating too fast and stealing food which is a choking risk." Client #2's dysphagia risk plan in his record book indicated a diet of "mechanical soft."</p> <p>Record review indicated Client #2's physician's orders dated 1/1/15 indicated a physician's order for "puree" diet.</p> <p>On 1/23/15 at 2:05 PM during an interview, the House Manager [HM] indicated Client #2's dysphagia risk plan indicated "puree diet" and provided documentation from the group home. The HM indicated the nurse and QIDP (Qualified Intellectual Disabilities Professional) were new to their positions and were in the process of auditing all the documentation for accuracy. The HM indicated she thought the QIDP had changed the diet order to puree when Client #2's diet order changed but did not update the record book in the office.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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><b>3)</b> On 1/20/15 at 2:31 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/7/14 to 1/20/15 and facility's internal incident/accident (I/A) reports from 10/27/14 to 1/20/15 were reviewed. A BDDS report dated 10/5/14 indicated "On 10-5-14 [Client #5] was drying off in the bathroom after his shower. [Client #5] lost his balance and fell backwards onto the wall and ending [sic] up sliding into the tub. [Client #5] has a 1/2 to 3/4 of an inch scratch on his upper left buttocks and possible bruising." The report indicated "[Client #5]'s team will continue to follow his fall plan to prevent future falls from taking place. If a pattern of falls develops [Client #5]'s team will meet to review his current fall plan."</p> <p>A BDDS report dated 10/8/14 indicated "staff was helping a consumer get out of bed when [Client #5] starting [sic] getting up by himself. Staff asked for him to wait a minute while she finished with the other consumer. Staff was on the left side of [Client #5], when [Client #5] got up on right side of his bed and started going towards the bathroom." The report indicated "[Client #5] tripped over a chair in the room rushing to get to the bathroom. When [Client #5] fell, he hit his nose on the floor and it began bleeding. The staff followed precautions</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>for universal Blood [sic] and body fluid by wearing gloves, cleaning area and disposal. The staff took him to the [emergency room] where the Doctor stopped the bleeding and said that [Client #3] [sic] nose was broken. He also stated that there was no reason to do an X-ray or reset the nose except for appearance." The report indicated "the chair was removed from his room. Staff will continue to follow his fall plan."</p> <p>A follow up BDDS report dated 10/14/14 indicated "[Client #5] is doing well. He has had no further issues with his nose. He has not complained of pain or indicated that his nose is bothering him." The report indicated "[Client #5] does not need to see his physician for any additional follow up. Staff continue to assist [Client #5] when he ambulates, as he tends to walk quickly."</p> <p>On 1/21/15 at 1:58 PM, record review indicated Client #5's diagnoses included, but were not limited to, profound intellectual disabilities, autism, severe organic dysfunction, and agitated behavior organic personality syndrome. Client #5's ISP (Individual Support Plan) dated 10/10/14 indicated Client #5 "needs assistance while ambulating. [Client #5] is unsteady when he first stands from a seated position. He has a Fall</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>Management plan in place to include a gait belt so staff can help him steady himself before he ambulates." Client #5's ISP indicated "[Client #5] has injured himself in the past by moving too quickly, when he becomes agitated."</p> <p>Record review indicated Client #5 had a "Risk Plan Compilation" dated 10/10/14 which indicated a "Fall Management Plan". Client #5's fall plan indicated "has a history of getting up quickly and walking too fast which can cause falling." The plan indicated the following "interventions":</p> <p>"*Staff should walk with me when there is any type of terrain changes due to being unsteady from seizure medication.</p> <p>*Staff should be aware that I move quickly when getting out of seated position and initiating ambulating from place to place and be there for support and stability if I need it.</p> <p>*I utilize a shower chair due to general dizziness and poor balance. I use shower chair to help me from falling in the shower. Staff will assist in washing and transferring in and out of my shower chair while showering."</p> <p>Client #5's fall plan indicated staff should</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>monitor "terrain changes", "transferring to and from seated position", and "showering." Client #5's fall plan did not include the use of a gait belt.</p> <p>Record review indicated Client #5's physician's orders dated 1/1/15 included no order for gait belt. Client #5's "Monthly Nurse's Notes" dated 10/2014 indicated "incident report 10/5/2014 r/t (resulted from) fall resulting in 1/2 inch scratch to upper left buttocks. Fall plan in place and followed." The notes indicated "10/08/2014 fall with injury/ER (emergency room) visit - broken nose (instructions noted: return to ER if recurrent nose bleed, no x-rays done). [Physician] suggested repair to nose would only be cosmetic and need referral to ENT (ear nose throat specialist). Fall plan in place and followed." Record review indicated Client #5 had a medication change on 10/15/14 by his neurologist. Record review indicated Client #5 had a neurology appointment on 1/15/15 which indicated "he has been more alert, better balance (sic) - less falls, staff seen (sic) a difference pretty quickly."</p> <p>Record review indicated Client #5 had a PT (physical therapy) appointment on 12/12/12 which indicated the recommendation "gait belt placement at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>hips or chest depending caregiver preference c (with) belt height, holding onto back of belt in center/midline." Record review indicated Client #5 had a PT appointment on 12/22/14 which indicated "continue current program."</p> <p>On 1/23/15 at 2:05 PM in a concurrent interview with the Administrator and the House Manager (HM), the Administrator indicated Client #5 was getting out of bed while staff were assisting another client. The Administrator stated "staff told him to wait but he did not wait." When asked why staff did not immediately assist Client #5 when he began to get out of bed without staff assistance, the Administrator stated she did not know but "maybe staff were not at a good time to assist." The Administrator indicated Client #5's physician's orders did not include an order for the gait belt. The House Manager [HM] indicated Client #5 does use a gait belt in the home. The HM stated Client #5's use of gait belt was in "his original plan" but did not get transferred over to "the new compilation" format. In regards to Client #5's fall in the bathroom on 10/5/14, the HM stated Client #5 "probably" did not have his gait belt on because staff said he was drying off and he would have been unclothed. The HM indicated Client #5 does use a shower chair but indicated Client #5's fall</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/27/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
(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>plan did not indicate the level or type of supervision while drying off between the time he stands up from the shower chair to the time he has his gait belt on. The HM indicated the facility nurse and QIDP (Qualified Intellectual Disabilities Professional) were new to their positions and were beginning to audit the records to ensure accuracy. She indicated Client #5's fall risk plan should be updated to include use of gait belt and a bathroom safety protocol.</p> <p>4) A BDDS report dated 6/29/14 indicated "staff was assisting [Client #7] to the bathroom. [Client #7] reached for the metal bar on the wall, missed it and fell over the (sic) forward hitting the toilet with arm and leg. Staff lowered him to the floor and checked for any serious injuries before getting him back up. Once staff had him sitting, staff assessed him. [Client #7] has a scrape the size of a nickel on left elbow and just under that there is another scrape about 2 inches long. He has a bruise on inside of left thigh about 1 inch in diameter." The report indicated "Staff will continue to follow [Client #7]'s fall plan of walking beside him using his gait belt."</p> <p>A BDDS report dated 10/5/14 indicated "during the night of 10-4-14 [Client #7] was standing in his bedroom holding</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>onto his dresser. [Client #7] lost his balance/strength in his arms and fell forward into the dresser and then down to the floor. [Client #7]'s face was red but no other injuries were found at the time of accident. On the morning on 10-5-14 staff checked [Client #7] and found his right cheek was still red and slightly swollen." The report indicated "staff will assist [Client #7] while he is standing to help prevent future falls. Staff will continue to monitor [Client #7] to ensure he is not showing any signs of concussion."</p> <p>A BDDS report dated 10/19/14 indicated "during the day of 10-18-14 [Client #7] was walking with staff when he stumbled and fell to the ground. Staff held him by his gait belt and let him down to the ground. No injuries were found at the time of the fall. However, during the morning of 10-19-14 staff found a carpet rash on [Client #7]'s forehead by his hair line. The rash is about the size of a quarter." The report indicated "[Client #7] became excited due to being close to his chair and the excitement cause [sic] [Client #7] to fall forward. Staff followed [Client #7]'s fall risk plan by utilizing [Client #7]'s gait belt while he was ambulating. Staff assisted [Client #7] to the ground when he began to show signs of falling."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>On 1/21/15 at 2:03 PM, record review indicated Client #7's diagnoses, included but were not limited to, profound intellectual disabilities, OCD (obsessive compulsive disorder), organic personality disorder, probable seizures, and Parkinson's disease. Client #7's physician's order dated 1/1/15 indicated "staff to use gait belt to assist with ambulation."</p> <p>Record review indicated Client #7's ISP (Individual Support Plan) dated 7/24/14 indicated "[Client #7] has some difficulty getting up from his favorite chair, staff should not pull him up, but encourage him to get up on his own, with an assistive device, if necessary. Client #7's ISP indicated a "Risk Plan Compilation" dated 7/24/14 which did not indicate Client #7 had a current fall risk plan or indication for gait belt use.</p> <p>Record review indicated Client #7 had a PT (physical therapy) appointment on 10/17/13 which indicated "gait belt to assist with ambulation." Record review indicated Client #7 had a PT appointment dated 12/31/14 which indicated the recommendation "continue assist c (with) 2 (staff) and continue yearly eval (evaluation)."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
--	---

(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>On 1/23/15 at 2:05 PM during a concurrent interview, the Administrator indicated the House Manager (HM) usually ensures fall plans were followed and assesses the environment routinely for fall hazards. The Administrator indicated falls and trends of falls are monitored by the facility's Quality Assurance Committee. The HM indicated Client #7's "Risk Plan Compilation" in the record book in the office was an incorrect version. The HM indicated Client #7's current fall risk plan stated "staff will assist" but did not indicate how many staff. The HM indicated the fall risk plan was not updated to include the 12/31/14 PT (physical therapist) recommendation for Client #7 to ambulate with 2 staff assistance with use of gait belt.</p> <p>9-3-6(a)</p>			