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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G698 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>12/08/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>CARDINAL SERVICES INC OF INDIANA | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1300 MITCHEL ST<br>ROCHESTER, IN 46975 |
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| W000000            | <p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: 12/1, 12/2, 12/3, 12/4, 12/5, and 12/8/14.</p> <p>Provider Number: 15G698<br/>Facility Number: 003238<br/>AIM Number: 200371780</p> <p>Surveyor:<br/>Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.<br/>Quality Review completed 12/16/14 by Ruth Shackelford, QIDP.</p>               | W000000       |  |                      |
| W000104            | <p>483.410(a)(1)<br/>GOVERNING BODY<br/>The governing body must exercise general policy, budget, and operating direction over the facility.<br/>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and three additional clients (clients #5, #6, and #7), the governing body failed to exercise operating direction over the facility to ensure routine maintenance was completed for the worn and damaged</p> | W000104       | <p>Recliner was removed from the home and a replacement will be purchased by 01/07/2015. RM spoke with the maintenance man on 12/05/2014 about the couches needing repaired. Repairs will be completed by 01/07/2015. (attachment 1) Cardinal Services will reimburse client #4 \$140.70 for his Orthotic's and Orthotic</p> | 01/07/2015           |

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.

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|  | <p>furniture and failed to ensure client #4 was not charged for services and equipment the facility was to provide.</p> <p>Findings include:</p> <p>1. On 12/2/14 from 9:45am until 11:15am, on 12/2/14 from 3:00pm until 6:05pm, and on 12/3/14 from 6:20am until 8:40am, observation and interview were conducted at clients #1, #2, #3, #4, #5, #6, and #7's group home. During the observation periods one of two rocker recliners in the men's side living room had worn fabric covering the back of the recliner. The foam padding was observed through the thin protective covering. During the observation periods the wooden sofa on the women side had chips into the wood. On 12/3/14 at 8:00am, the Residential Manager (RM) indicated clients #1, #2, #3, #4, #5, #6, and #7 used the worn recliner on the men's side of the group home. The RM indicated a previous client had owned the recliner and left the worn recliner at the group home in the living room. The RM indicated the women's side sofa had chips into the wood and was damaged.</p> <p>On 12/4/14 at 12:20pm, an interview with the Community Services Coordinator (CSC) and QIDP (Qualified Intellectual Disabilities Professional) was</p> |   | Shoes by 01/07/2015. Cardinal will have the Orthotic company bill Medicare/Medicaid for these items. RM will be retrained on the procedure of denied medical claims and Cardinal's responsibilities of coverage by 01/07/15. |   |  |   |  |

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|                    | <p>conducted. The CSC and QIDP both indicated the worn recliner needed to be replaced and the sofa on the women's side had damage into the wood and needed to be repaired.</p> <p>2. On 12/3/14 at 8:00am, client #4's financial records were reviewed with the RM (Residential Manager) was conducted. Client #4's financial record included a check number 1137 for an entry on 7/2014 "[Name of Orthotic Business]" into client #4's bank book for "\$140.70" from client #4's personal funds account.</p> <p>On 12/4/14 at 10:30am, client #4's record was reviewed. Client #4's 3/11/14 ISP (Individual Support Plan) indicated he had a guardian of his person and could not advocate for himself. Client #4's record indicated client #4's physician, 3/20/14 PT (Physical Therapy) evaluation, and 3/20/14 OT (Occupational Therapy) evaluation indicated the need for client #4's Orthotic inserts and Orthotic shoes to assist client #4 for standing and transferring from his wheel chair to other locations to sit. Client #4's record included a 7/14/14 Invoice date for "Date of Service 6/5/14" from "[Name of Orthotic Business]...Joint Contracture (Diagnosis)...Orthopedic Men's Shoes</p> |               |   |                      |

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| W000149            | <p>Oxford (for) \$140.70, and Full Sole heel Wedge Btween (Between) (for) \$104.20" final charges \$140.70 for payment from client #4's personal funds account.</p> <p>On 12/4/14 at 12:20pm, an interview with the Community Services Coordinator (CSC) and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC and QIDP both indicated client #4's wore Orthotic and special Orthopedic shoes because of his physical needs. Both indicated the agency's financial office determines what each client should pay for and what the agency paid for. The CSC indicated client #4 had charges to his personal funds from his Orthotic's and Orthotic Shoes. The CSC stated the facility's rate was "all inclusive."</p> <p>9-3-1(a)</p> <p>483.420(d)(1)<br/>STAFF TREATMENT OF CLIENTS<br/>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, for 1 of 15 BDDS (Bureau of Developmental Disabilities Services) reports reviewed which included 1 of 2 allegations of abuse/neglect (client #4), the facility neglected to implement their</p> | W000149       | Staff was suspended immediately and terminated at the end of the investigation. Coordinator retrained on Abuse/Neglect policy, specifically about reporting abuse, neglect, and exploitation immediately at the house meeting 12-15-2014. (attachment 2,3,4 ) | 12/15/2014           |

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|                    | <p>policy and procedure to immediately report allegations of substantiated staff to client abuse/neglect and to protect client #7 from the potential of further abuse, neglect, and/or mistreatment.</p> <p>Findings include:</p> <p>On 12/1/14 at 1:50pm and on 12/2/14 at 1:00pm facility's BDDS (Bureau of Developmental Dis Services) reports and investigations from 12/20 through 12/1/14 were reviewed.</p> <p>-A 6/24/14 BDDS report for an incident on 6/27:00pm, indicated client #7 "was going in and c home continuously during a storm and [Group Staff (GHS) #8] kept redirecting [client #7] into home. After many attempts of redirecting [client #8] yelled across the home It's thundering lightning you stupid idiot stay in the house. A staff heard this and reported it to the RM (Resid Manager) on 6/24/14." The report indicated G was suspended on 6/24/14 pending an investigation.</p> <p>-A 7/2/14 Follow Up BDDS report indicated "S interviewed and gave written statements. All individuals working that evening stated they he staff make this statement. Staff working the ne gave statement that they reported it to her too a she knew she was going to get a phone call for #8] was interviewed and gave a written statement admitted that she had said it and as soon as she couldn't believe she had just said that and apologize the consumer while she was helping him back i</p> |               | <p>Staff are quizzed weekly during RM, QDP, and Coordinator observations. They are given different scenarios and are required to explain what actions they would take. The abuse/neglect policy will be discussed at each house meeting monthly.(attachment 5 )</p> |                      |

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|                    | <p>home. Staff was terminated for verbal abuse. 4 staff involved in the incident were retrained on of abuse/neglect."</p> <p>On 12/1/14 at 1:50pm, an interview with the Community Services Coordinator (CSC) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the CSC and the QIDP indicated the allegations against GHS #8 for the 6/21/14 incident involving client #7 was staff abuse at the group home. The CSC indicated GHS #8's substantiated abuse and neglect occurred at 7:00pm on 6/21/14 and GHS #8 was allowed to finish her shift of work on 6/21/14 and work on 6/22/14, 6/23/14, and until 6/24/14 because the staff at the group home neglected to immediately report the incident to the RM.</p> <p>On 12/1/14 at 1:15 PM, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an</p> |               |   |                      |

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| W000153            | <p>individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."</p> <p>On 12/2/14 at 1:15 PM, the facility's 7/2012 "Incident/Abuse/Neglect Policy" was reviewed. The policy indicated "Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated (sic); incidents will be reported and thoroughly investigated as outlined in this policy...Reportable Incidents...All injuries of unknown origin and allegations of abuse, neglect, and mistreatment must be reported to the administrator immediately."</p> <p>9-3-2(a)</p> <p>483.420(d)(2)<br/>STAFF TREATMENT OF CLIENTS<br/>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> |               |   |                      |

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|  | <p>Based on record review and interview, for 1 of 15 BDDS (Bureau of Developmental Disabilities Services) reports reviewed which included 1 of 2 allegations of abuse/neglect (client #4), the facility failed to immediately report an allegation of staff to client abuse to the administrator in accordance with State Law.</p> <p>Findings include:</p> <p>On 12/1/14 at 1:50pm and on 12/2/14 at 1:00pm facility's BDDS (Bureau of Developmental Dis Services) reports and investigations from 12/20 through 12/1/14 were reviewed.</p> <p>-A 6/24/14 BDDS report for an incident on 6/2 7:00pm, indicated client #7 "was going in and c home continuously during a storm and [Group Staff (GHS) #8] kept redirecting [client #7] into home. After many attempts of redirecting [clie [GHS #8] yelled across the home It's thunderin lightening you stupid idiot stay in the house. A staff heard this and reported it to the RM (Resic Manager) on 6/24/14." The report indicated Gl was suspended on 6/24/14 pending an investigæ</p> <p>-A 7/2/14 Follow Up BDDS report indicated "S interviewed and gave written statements. All individuals working that evening stated they he staff make this statement. Staff working the ne gave statement that they reported it to her too a she knew she was going to get a phone call for</p> | W000153   | <p>Staff was suspended immediately and terminated at the end of the investigation. Coordinator retrained on Abuse/Neglect policy and reporting of incidents at the house meeting 12-15-2014. Training was specifically about immediate reporting of abuse, neglect, and exploitation. (attachment 2,3,4) Staff are quizzed weekly during RM, QDP, and Coordinator observations. They are given different scenarios and are required to explain what actions they would take. The abuse/neglect policy will be discussed at each house meeting monthly.(attachment 5 )</p> | 12/15/2014  |  |   |  |

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| W000218  | <p>#8] was interviewed and gave a written stateme admitted that she had said it and as soon as she couldn't believe she had just said that and apolc the consumer while she was helping him back i home. Staff was terminated for verbal abuse. , staff involved in the incident were retrained on of abuse/neglect."</p> <p>On 12/1/14 at 1:50pm, an interview with the Community Services Coordinator (CSC) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the CSC and the QIDP indicated the allegation against GHS #8 for the 6/21/14 incident involving client #7 was staff abuse at the group home and the allegation was not immediately reported to the administrator. The CSC indicated GHS #8's substantiated abuse occurred at 7:00pm on 6/21/14 and GHS #8 was allowed to finish her shift of work on 6/21/14 and work on 6/22/14, 6/23/14, and until 6/24/14 because the staff at the group home failed to immediately report the incident to the RM.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v)<br/>INDIVIDUAL PROGRAM PLAN<br/>The comprehensive functional assessment must include sensorimotor development. Based on observation, record review, and interview, for 2 of 2 sampled clients</p> | W000218   | QDP completed a basic functional assessment of blindness and blind risk plans of                                | 01/07/2015  |  |   |  |

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|  | <p>(clients #1 and #4) who were visually impaired, the facility failed to assess client #1 and #4's functional ability related to their blindness.</p> <p>Findings include:</p> <p>1. On 12/2/14 from 9:45am until 11:15am, on 12/2/14 from 3:00pm until 6:05pm, and on 12/3/14 from 6:20am until 8:40am, observation and interview were conducted at client #1's group home. Client #1 repeatedly placed a hat to cover her head and face. Throughout both observation periods client #1 was observed to be blind. Client #1 walked with a shuffled gait a couple of steps independently and would stop and stand waiting for a staff to assist her. Throughout the observation periods client #1 was assisted by staff to walk forward and no description of where they were walking was verbalized by the staff. While walking with the group home staff client #1 was assisted by staff guiding client #1's shoulders from behind client #1, pulling client #1 by the hand forward, holding hands to walk forward, and client #1 held one of five staff who assisted her by the inside of the staffs arm to walk. Throughout the observation periods client #1 was assisted by staff to eat prepared foods, foods were not identified at the evening meal, and no description of</p> |   | <p>client #1 and #4 on 12/22/14. (attachment 6,7) QDP will train staff on the risk plan by 01/07/15. QDP contacted Bosma on 12/17/14 and completed the intake process. Bosma will be contacting us after January 2015 to set up initial assessments of all blind consumers in the home.</p> |   |  |   |  |

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|  | <p>where the foods were located on her plate were verbalized during the meals or snacks provided.</p> <p>On 12/4/14 at 11:30am, client #1's record review was conducted. Client #1's 3/11/14 ISP (Individual Support Plan) indicated she was blind and the goals/objectives did not include interventions for staff to use related to client #1's blindness. Client #1's 3/2014 CFA (Comprehensive Functional Assessment) and 3/11/14 SMP (Self Management Plan) did not indicate client #1 was blind. Client #1's 9/23/14 "Physician's Order" indicated a diagnosis of "Cataracts Bilateral...Severe Retinal Degeneration (Blindness)." Client #1's 4/11/12 Vision evaluation indicated "Patient very uncooperative...Cataract/poor vision...considered Legally Blind at this time." Client #1's 5/2/14 Vision evaluation indicated "Based on observations patient has less than 20/200 vision in the best eye. Patient very uncooperative...Cataract/poor vision...Considered Legally Blind at this time." Review of the record did not indicate a sensorimotor assessment for client #1's functional blindness. Client #1's record did not indicate what or how staff were to assist client #1 to function in her environment related to her</p> |  |  |  |
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|  | <p>blindness.</p> <p>2. On 12/2/14 from 3:00pm until 6:05pm, and on 12/3/14 from 6:20am until 8:40am, client #4 used a wheel chair to move throughout the group home. During both observation periods client #4 was observed to be visually impaired. During both observation periods client #4 moved his wheel chair independently throughout the group home and ran his wheel chair into objects, people, furniture, and doorways. During both observation periods client #4 became upset after running into objects and when other clients began to make sounds and loud noises. Client #4 moved his wheel chair in jerky motions, tilted his wheel chair back on two wheels, verbalized profane language, and rammed his wheel chair into walls. During each of these episodes group home staff would verbally reassure client #4, attempt to calm client #4, and on three occasions removed client #4 in his wheel chair from the immediate vicinity of the other aggressive clients to client #4's bedroom. Throughout the observation periods client #4 was assisted by staff to eat prepared foods, foods were not identified at the evening meal, and no description of where the foods were located on his plate were verbalized during the meals or snacks provided.</p> |   |   |   |  |   |  |

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|  | <p>On 12/4/14 at 10:30pm, client #4's record review was conducted. Client #4's 3/11/14 ISP (Individual Support Plan) indicated he was blind. Client #4's ISP goals/objectives did not include interventions staff were to employ related to his blindness. Client #4's 3/2014 CFA (Comprehensive Functional Assessment) and 3/11/14 SMP (Self Management Plan) did not indicate client #4 was blind. Client #4's 9/23/14 "Physician's Order" indicated a diagnosis of "Blind." Client #4's 3/8/13 Vision evaluation indicated his eyes were stable. Client #4's 2/11/11 Vision evaluation indicated "Eye Exam and Blind Assessment...vision: Legally Blind" no treatment "at this time" and client #4's ocular health was stable. Review of the record did not indicate a sensorimotor assessment for client #4's functional blindness. Client #4's record did not indicate what or how staff were to assist client #4 to function in his environment related to her blindness.</p> <p>On 12/4/14 at 12:20pm, an interview with the Community Services Coordinator (CSC) and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC and QIDP both indicated clients #1 and #4 were blind and no sensorimotor assessments were available for review for client #1 and #4's</p> |  |  |  |
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| W000436            | <p>functional blindness.</p> <p>9-3-4(a)</p> <p>483.470(g)(2)<br/>SPACE AND EQUIPMENT<br/>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br/>Based on observation, record review, and interview, for 1 of 1 sampled client (client #4) with adaptive equipment, the facility failed to provide client #4's wheel chair in good repair.</p> <p>Findings include:</p> <p>On 12/2/14 from 3:00pm until 6:05pm, and on 12/3/14 from 6:20am until 8:40am, client #4 used a wheel chair to move throughout the group home.<br/>During both observation periods client #4's wheel chair had two of two arm rests with exposed metal and worn fabric torn from wheel chair hanging off each arm rest. During both observation periods client #4 rested his arms against the exposed metal of the wheel chair. On 12/3/14 at 8:00am, the Residential Manager (RM) indicated client #4's arm rests on his wheel chair had worn</p> | W000436       | <p>Arm rests were replaced on wheelchair on 12/08/2014. Staff were trained on 12/15/14 about the procedure to report any issues with adaptive equipment during their cleaning and evaluation of all adaptive equipment. (attachment 2,8 ) RM will be retrained on adaptive equipment repair and replacement by 01/07/15. RM and Coordinator will monitor for compliance through observations to ensure staff competency. (attachment 5)</p> | 01/07/2015           |

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| W000454            | <p>material and exposed metal.</p> <p>On 12/4/14 at 10:30pm, client #4's record review was conducted. Client #4's 3/11/14 ISP (Individual Support Plan) indicated he used a wheel chair to allow him independent mobility. Client #4's 3/20/14 PT (Physical Therapy) assessment indicated client #4 used a wheel chair for mobility.</p> <p>On 12/4/14 at 12:20pm, an interview with the Community Services Coordinator (CSC) and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC and QIDP both indicated client #4's wheel chair needed to be repaired.</p> <p>9-3-7(a)</p> <p>483.470(l)(1)<br/>INFECTION CONTROL<br/>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br/>Based on observation, record review, and interview, for 1 of 4 sample client (client #1) who used a pill crusher for medications, the facility failed to follow Universal Precautions for two of two soiled pill crushers stored as clean.</p> | W000454       | Nurse trained staff on 12/15/14 house meeting on proper procedures for pill crushers. (attachment 2,9 ) RM and Nurse will increase observations of medication passes until staff demonstrate competency. Once competency is established, normal | 12/15/2014           |

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|  | <p>Findings include:</p> <p>On 12/2/14 from 9:45am until 11:15am, on 12/2/14 from 3:00pm until 6:05pm, and on 12/3/14 from 6:20am until 8:40am, observation and interview were conducted at clients #1, #2, #3, #4, #5, #6, and #7's group home. During the observation periods two of two pill crushers were stored as clean in the medication room upside down on a dark blue wash cloth. On 12/2/14 at 4:10pm, Group Home Staff (GHS) #1 assisted client #1 to walk to the medication room. At 4:10pm, GHS #1 selected one of two used pill crushers with a powdered residue on both and stored as clean from on top of the medication cabinet. GHS #1 ground client #1's tablet medications inside the used pill crusher, emptied the ground contents into a medication cup, and administered the medication to client #1. At 4:10pm, GHS #1 took the used pill crusher with ground residue added from client #1's medication and returned the used pill crusher to an upside down position on top of the dark blue wash cloth on top of the medication cabinet. The used pill crusher was kept in the location until the next medication pass. At 4:15pm, the surveyor picked up two of two pill crushers from the dark blue wash cloth, returned each to the same position on the wash cloth, and the movement of</p> |   | observation schedule will be observed. (attachment 5)   |   |  |   |  |

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|  | <p>both pill crushers caused white and cream colored substance to fall from both pill crushers onto the dark blue wash cloth. At 4:15pm, GHS #1 indicated the substances fell from each pill crusher. GHS #1 indicated both pill crushers had a white and cream colored build up on the rims and inside each pill crusher. On 12/3/14 at 7:17am, GHS #3 administered client #1's morning medications inside the medication room. GHS #3 selected one of two soiled pill crushers from the dark blue wash cloth from on top of the medication cabinet. GHS #3 ground client #1's oral medication inside the soiled pill crusher, poured the medication into a medication cup, and administered the medication to client #1. GHS #3 replaced the used pill crusher in the same upside down position on top of the medication cabinet on top of the dark blue wash cloth. GHS #3 indicated the pill crushers had a build up inside each pill crusher. At 7:27am, GHS #3 left the medication room and both used pill crushers remained on the dark blue wash cloth.</p> <p>On 12/4/14 at 12:20pm, a record review and interview with the agency Licensed Practical Nurse (LPN) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The LPN and QIDP indicated facility staff should</p> |  |  |  |
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|  | <p>have followed Core A/Core B medication training manual, dated 2004, for Universal Precautions. On 12/4/14 at 12:20pm, the Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions should also be used when cleaning personal items...." No specific facility policy nor procedure was available for review for the care and cleaning of the pill crushers. The LPN indicated client #1's pill crushers should have been clean and free of debris.</p> <p>On 12/4/14 at 12:20pm, an interview with the Community Services Coordinator (CSC) and QIDP was conducted. The CSC and QIDP both indicated the pill crushers should have been cleaned after each use.</p> <p>9-3-7(a)</p> |   |   |   |  |   |  |