

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2013
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 330 E COLUMBIA LOGANSPORT, IN 46947
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: 12/2, 12/3, 12/5, 12/6, 12/9, 12/13, and 12/16/2013.</p> <p>Facility Number: 001063 Provider Number: 15G549 AIM Number: 100245450</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/19/13 by Ruth Shackelford, QIDP.</p>	W000000		
W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review, and inter-1 of 1 sampled client (client #1) who attended outside contracted workshop for day services, facility failed to ensure the contracted workshop client #1's identified supervision needs and fail ensure client #1 was not left alone.</p> <p>Findings include:</p>	W000120	<p>Outside Agency has been instructed that they must visually see staff when they drop the consumer off. Outside Agency will also contact staff if they need to adjust the schedule and either drop the consumer off earlier or later than the weekly schedule states. The outside agency was given a list of contact numbers that they can utilize for scheduling</p>	01/14/2014

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>On 12/2/13 at 11:25am, the facility's BDDS (E Developmental Disabilities Services) reports f 12/2012 through 12/2/13 were reviewed.</p> <p>-A 10/28/13 BDDS report for an incident on 1 at 1:45pm, indicated client #1 was "with [the s the contracted outside workshop] and was sch be there until 2:30pm." The report indicated t clients and staff on duty from the group home for a Halloween party in a town thirty minutes away from the group home at 11:30am. The r indicated the clients and staff "returned to the around 1:45pm. When they arrived they foun #1] sitting in the home alone." The report ind: staff called to report the incident to the admini and the RM (Residential Manager) "contacted contracted outside workshop] to see why [clie was home alone. They stated they had droppe at 12:45pm and assumed that staff were in the because there were cars outside the home. No contracted workshop] staff entered the home t sure of this. They also stated they had not call home to let anyone know that they would be d [client #1] off one (1) hr (hour) and 45 (forty-i (minutes) early. [Client #1] was alone for abo</p> <p>-The 11/7/13 BDDS Follow up report indicate #1] requires 24hr. care. She does not have alo time...The team does feel that [the outside con workshop staff] failed to follow proper safety procedures with their lack of communication.'</p> <p>Client #1's record was reviewed on 12/5/13 at Client #1's 4/23/13 ISP (Individual Support Pl</p>		<p>changes. The outside agency must make contact with someone on that list, before changes can be made. This was all completed immediately after the reported incident occurred. (attachment 2-3) Completed 10-26-13 QDP will complete abuse/neglect and reporting of incidents retraining with all staff at house meeting on 01-14-13. (attachment1) Increased monitoring for compliance with the outside agency has occurred by the RM until RM was satisfied that compliance was met. Outside Agency staff have been walking consumer inside to ensure that staff are in the home.</p>	

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	<p>indicated client #1 "required 24 hour supervisi did not have the skills to be home alone indep Client #1's 4/23/13 CFA (Comprehensive Fun Assessment) indicated client #1 did not posses skills to be home alone, to independently use t telephone, and/or to know what to do in the ev emergency. Client #1's 4/23/13 SMP (Self Management Plan) indicated "I have in the pa outside without staff while I'm upset and not i them that I am leaving. I do not possess street skills when I am upset and should not be outsi without staff...If I am in a heightened emotion staff should accompany me outside if I wish to door alarms are currently in place for my safet</p> <p>On 12/5/13 at 9:45am, an interview with the Community Services Coordinator (CSC) and the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted. Both the CSC and the QIDP/PD indicated client #1 did not possess community street safety skills and did not possess being alone at home skills. The QIDP/PD indicated client #1 was not supervised based on her identified need when client #1 was left home alone by the contracted workshop staff. The QIDP/PD indicated the contracted workshop staff did not provide client #1 with supervision on 10/25/13.</p> <p>9-3-1(a)</p>			

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview, and record review, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to allow and encourage unimpeded access to locked chemicals at the group home.</p> <p>Findings include:</p> <p>On 12/2/13 from 1:16pm until 5:45pm, and on 12/3/13 from 5:46am until 7:40am, observation at group home was completed and clients #1, #2, #3, #4, #5, #6, #7, and #8 walked and/or accessed each room throughout the group home independently. On 12/2/13 from 1:16pm until 5:45pm, the chemical closet was locked and staff had the key. On 12/3/13 from 5:46am until 6:50am, the chemical closet was unlocked. At 6:55am until 7:40am, the chemical</p>	W000125	<p>The door is to be left unlocked at this time. QDP will retrain staff on this on 01-14-2014 at house meeting. (attachment 1) QDP will review the proper completion of CFA's with the staff. (attachment 1) Staff will be monitored for compliance through increased weekly observations by QDP, RM, and Coordinator until satisfied that home is back in compliance and no issues occur. (attachment 4)</p>	01/14/2014			

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	<p>closet was locked and the facility staff had the key. At 6:50am, GHS #6 indicated the closet should be locked and stated "only" facility staff had a key to the locked chemicals. At 6:50am, GHS #6 unlocked the locked chemical closet to show the chemicals which were kept secured: bathroom cleaners, toilet bowl cleaners, bleach, Windex, Clorox cleaners, furniture polish, and assorted tub/tile cleaners.</p> <p>Client #1's record was reviewed on 12/5/13 at 12:10pm. Client #1's 4/23/13 CFA (Comprehensive Functional Assessment) did not indicate the identified need for locked chemicals.</p> <p>Client #2's record was reviewed on 12/5/13 at 10:40am. Client #2's 6/12/13 CFA (Comprehensive Functional Assessment) did not indicate the identified need for locked chemicals.</p> <p>Client #3's record was reviewed on 12/5/13 at 9:40am. Client #3's 9/10/13 CFA (Comprehensive Functional Assessment) did not indicate the identified need for locked chemicals.</p>			

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	<p>Client #4's record was reviewed on 12/5/13 at 11:40am. Client #4's 3/20/13 CFA (Comprehensive Functional Assessment) did not indicate the identified need for locked chemicals.</p> <p>On 12/5/13 at 9:45am, an interview with the Community Services Coordinator (CSC) and the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted. Both the CSC and the QIDP/PD indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 did not have an identified need for locked chemicals in the group home. The QIDP indicated client #3 had a prior history of ingesting chemicals and had not ingested non-edible items for several years. The QIDP indicated no plans were in place for locked chemicals. The QIDP indicated the chemicals inside the group home should not have been locked.</p> <p>9-3-2(a)</p>			

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W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 2 of 2 sampled clients (clients #1 and #2) and for 2 additional clients (clients #7 and #8), the facility failed to encourage and teach personal privacy during client #1, #2, #7, and #8's medication administration.</p> <p>Findings include:</p> <p>On 12/3/13 from 6:25am until 6:55am, clients #1, #2, #7, and #8 had their morning medications administered by GHS (Group Home Staff) #7 on the female side of the group home at the kitchen counter. During the medication administration time clients #1, #2, #7, and #8 sat at the dining room table within feet of the kitchen counter and watched medications administered by GHS #7 to the other clients. GHS #7 named each medication, their use, and the side effects for each medication administered. Clients #1, #2, #7, and #8 interrupted one another with verbal discussions between clients from the dining room table with clients who were receiving their medications at the kitchen counter with facility staff</p>	W000130	<p>Staff will be completing medication passes on the women's side in the women's bathroom for privacy issues. Staff began this 12-16-13. Nurse will complete medication privacy training with staff on 01-14-14. (attachment 1) RM completed a work request with maintenance on 12-31-13 to see if the locked medication cabinet could be moved out of the kitchen and into a more private area. (attachment 5) Staff will be monitored for compliance through increased observations by the Nurse, RM, QDP, and coordinator until satisfied that home is in compliance and then return to regular observation schedule. (attachment 4)</p>	01/14/2014			

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W000149	<p>without redirection. Clients #1, #2, #7, and #8 walked up to GHS #7 at the kitchen counter when she was administering other clients' medications and asked questions, washed their hands at the kitchen sink, and retrieved breakfast supplies from the kitchen cabinets.</p> <p>On 12/5/13 at 9:45am, an interview with the Community Services Coordinator (CSC) and the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted. Both the CSC and the QIDP/PD indicated clients #1, #2, #7, and #8 should have privacy and be taught personal privacy during their medication administration.</p> <p>9-3-2(a) 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, for 3 of 29 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (clients #2, #3, and #6), the facility neglected to implement their policy and procedure to prevent abuse, neglect, and/or mistreatment.</p>	W000149	<p>Staff was suspended immediately and terminated at the end of the investigation. QDP will retrain on Abuse/Neglect policy and reporting of incidents at the house meeting 01-14-2014. (attachment 1) Staff will be monitored for compliance through increased observations by RM, QDP, and Coordinator until</p>	01/14/2014

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	<p>Findings include:</p> <p>On 12/2/13 at 11:25 AM, the facility's BDDS of Developmental Disabilities Services) report 12/2012 through 12/2/13 were reviewed.</p> <p>-A 9/29/13 BDDS report for an incident on 9/6:00 PM, indicated the RM (Residential Mana "received a call from [GHS (Group Home Sta that [GHS #5] had been yelling at [client #6] t he was drinking out of the bathroom sink and way in the kitchen." The report indicated the suspended GHS #5.</p> <p>-A 9/29/13 BDDS report for an incident on 9/6:00 PM, indicated the RM "received a call fr #4]...who stated that she was reporting abuse c consumers by [GHS #5]. [GHS #4] stated tha witnessed [GHS #5] yelling at the consumers ; saw [GHS #5] slap [client #2] in the mouth to to quiet down. [GHS #4] also reported that wl [GHS #4] was outside, the other [group home the group home] reported that she also reporte GHS #4) that [GHS #5] also slapped [client #: back of the head." The report indicated the RI suspended GHS #5.</p> <p>-A 10/4/13 BDDS Follow up report for the inc 9/28/13 indicated the allegation of "abuse was substantiated" for clients #2, #3, and #6 and G was terminated from employment.</p> <p>On 12/5/13 at 11:30 AM, a review of GHS #5 "Employee Counseling Record" was conducte</p>		satisfied that home is in compliance and then return to regular schedule of observations. (attachment 4)	

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	<p>record indicated the investigation into the alle; that GHS #5 "verbally and physically abused" #2, #3, and #6 "was substantiated." The repor indicated "Staff witnessed [GHS #5] slap a co. (client #2) several times on the mouth (sic) be was yelling. [GHS #5] was heard telling this c to shut up and go to your room in a loud screa voice. [GHS #5] was also observed hitting an consumer (client #3) on the back of the head b she was leaning in her chair stating sit up, this ridiculous. [GHS #5] was also heard yelling a screaming at a third consumer (client #6) beca was getting drinks out of the bathroom and kit During the investigation, [GHS #5] admitted t at the third consumer. [GHS #5] also understc staff saw her actions towards the first two con. physical and verbal abuse."</p> <p>On 12/5/13 at 9:45am, an interview with the Community Services Coordinator (CSC) and the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted. Both the CSC and the QIDP/PD indicated the allegations against GHS #5 on 9/28/13 were physical and verbal abuse against clients #2, #3, and #6 at the group home. The CSC indicated GHS #5's abuse occurred throughout the shift until GHS #4 called the RM to report the allegations. The CSC indicated GHS #5 was an afternoon/evening shift staff person.</p>			

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	<p>On 12/2/13 at 11:15 AM, 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 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 12/2/13 at 11:10 AM, 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</p>			

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W000317	<p>allegations of abuse, neglect, and mistreatment must be reported to the administrator immediately."</p> <p>9-3-2(a)</p> <p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 1 of 4 sampled clients (client #4), the facility failed to evaluate client #4's status for an annual decrease or contraindication of his psychotropic medication.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 12/5/13 at 11:40pm. Client #4's 3/20/13 ISP (Individual Support Plan) and client #4's 3/20/13 SMP (Self Management Plan) indicated the targeted behaviors of SIB (Self Injurious Behavior) of biting his arms/wrists and swinging his arms. Client #4's plans indicated the use of Clonidine 0.1mg (milligrams) for behaviors 1/2 tablet AM (morning) and 1 tablet at HS (bedtime), Risperdal 0.5mg for behaviors 1 tablet every morning, and Risperdal 1mg 1 tablet</p>	W000317	<p>Coordinator retrained QDP on gradual withdrawal of drugs unless contraindicated on 12/31/13. (attachment 6) Coordinator will monitor QDP psych paperwork monthly to monitor compliance and when satisfied (no errors for 3 months), will return to random monthly paperwork monitoring.</p> <p>Client 4 has med reduction plan. It states, "Seth's Risperdal will be decreased when he has 7 incidents of SIB for 6 consecutive months." (This is a quarter of his average monthly behaviors) (attachment A)</p>	12/31/2013

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W000383	<p>every day at bedtime for behaviors.</p> <p>On 12/16/13 at 9:20am, an interview and a review of client #4's record with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP provided a review of client #4's 11/2013, 8/2013, 6/20/13, 4/20/13, and 1/17/13 "Psych (Psychiatric) Medication Reviews." The QIDP indicated client #4's Psych Medication Reviews did not indicate a change in client #4's psychiatric medications or a contraindication. The QIDP indicated client #4's record indicated the last psychotropic medication reduction was in 2011. The QIDP indicated client #4's Psychiatrist had changed within the past year and stated the doctor was not going to change client #4's psychiatric medications until the doctor "got to better know" client #4.</p> <p>9-3-5(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, the facility failed to secure the medication cabinet keys for 4 of 4 sample clients (#1, #2, #3, and #4)</p>	W000383	Nurse will retrain over the Medication Policy pertaining to storage and key safety at the house meeting on 1-14-14. (attachment 1) Staff will be	01/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G549		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2013	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 330 E COLUMBIA LOGANSPORT, IN 46947			
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	<p>and four additional clients (clients #5, #6, #7, and #8) who resided in the home.</p> <p>Findings include:</p> <p>On 12/3/13 from 5:46am until 7:40am, observation at group home was completed and clients #1, #2, #3, #4, #5, #6, #7, and #8 walked and/or accessed each room throughout the group home independently. From 5:46am until 6:30am, the keys to the medication cabinet were left on the kitchen counter unattended. At 6:30am, GHS (Group Home Staff) #7 indicated she had left the keys to the medication unattended on the kitchen counter. GHS #7 indicated the medication cabinet keys should have been kept on her person and stated "I forgot them."</p> <p>An interview was conducted on 12/16/13 at 9:20am, with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the medication keys should be kept secured when medications were not administered and the keys were not secured. The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had access to the medication keys to the medication cabinet. The QIDP indicated the facility followed "Living in the Community" for medication administration.</p>		<p>monitored for compliance by Nurse, RM, QDP, and Coordinator by increased observations until satisfied that home is in compliance and then return to regular observation schedule. (attachment 4)</p>				

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 330 E COLUMBIA LOGANSPOET, IN 46947
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	<p>On 12/5/13 at 11am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication cabinet keys should be kept secure.</p> <p>9-3-6(a)</p>			