

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 10381 S SR 15 SILVER LAKE, IN 46982
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of survey: August 6, 7, 8, 9, 12, 13, 14, 16, 19, and 20, 2013.</p> <p>Facility number: 003094 Provider number: 15G694 AIM number: 200352640</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/27/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon record review, observation and interview, the governing body failed to provide operating direction over the facility to ensure implementation of their policy and procedures to protect 1 of 4 sampled clients (client #4) and 2 additional clients (clients #6 and #8) from harm or potential harm by failing to administer medications per physician's orders for 2 of 22 reportable incidents reviewed, and failed for 2 of 4 sampled clients (clients #2, #3) and 1 additional client (client #8) to implement effective corrective action to ensure medications were correctly packaged to prevent error in administration for 3 of 22 reportable incidents reviewed. The facility failed to report to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law an undetermined number of incidents in which 1 sampled client (client #3) and 1 additional client (client #8) were placed at potential risk from medication errors when a pattern of incorrectly packaged client medications occurred, failed to timely report 1 of 22 reports reviewed involving client #8's tampered medication, and failed to document a thorough investigation into incidents of tampered or incorrectly packaged medication for clients (#3 and #8).</p> <p>Findings include:</p> <p>1. Please see W149. The governing body failed to exercise general policy and operating direction over the facility to ensure implementation of policy and procedures to protect 1 of 4 sampled clients (client #4) and 2 additional clients (clients</p>	W000104	W104 The governing body must exercise general policy, budget, and operating direction over the facility. Cardinal Services is committed to providing quality supports for the people that we serve that is free from risk and offers the greatest opportunity for implementation of all policies and procedures. The Governing Body has implemented corrective action and is confident that this action has resolved the concerns created by the condition of out of compliance. Please see W149 Please see W153 Please see W154 Please see W157	09/19/2013

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	<p>#6 and #8) from harm by failing to administer medications per physician's orders for 3 of 22 reportable incidents reviewed and failed for 1 of 4 sampled clients (client #2) and 1 additional client (client #8) to implement effective corrective action to ensure medications were correctly packaged to prevent error in administration for 3 of 22 reportable incidents reviewed. The facility failed to report to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) an undetermined number of incidents in which 1 sampled client (client #3) and 1 additional client (client #8) were placed at risk from medication errors when client medications were incorrectly packaged, failed to timely report 1 of 22 reports reviewed involving client #8's tampered medication and failed to document a thorough investigation into incidents of tampered or incorrectly packaged medication for clients (#3 and #8).</p> <p>2. Please see W153. The governing body failed to exercise general policy and operating direction over the facility for 1 sampled client (client #3), and one additional client (client #8) to ensure incidents in which clients were placed at risk from medication errors when client medications were incorrectly packaged were reported to the administrator and to BDDS in accordance to state law, and failed to timely report 1 of 22 reports reviewed involving client #8's tampered medication were reported to the administrator and to BDDS in accordance with state law.</p> <p>3. Please see W154. The governing body failed to exercise general policy and operating direction over the facility to ensure a thorough investigation into incidents of tampered or incorrectly packaged medication for 1 of 4 sampled clients (client #3), and 1 additional client (client #8) was documented.</p>			

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	<p>4. Please see W157. The governing body failed to exercise general policy and operating direction over the facility to implement effective corrective action to ensure medications were administered without error and correctly packaged to prevent error in administration for 2 of 4 sampled clients (clients #2 and #3), and for 2 additional clients (clients #6 and #8).</p> <p>9-3-1(a)</p>			

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to protect clients from harm/injury by failing to implement policy and procedures to administer medications per physician's orders for 3 of 22 reportable incidents reviewed involving 1 of 4 sampled clients (client #4) and 2 additional clients (clients #6 and #8) and failed for 1 of 4 sampled clients (client #2) and 1 additional client (client #8) to implement effective corrective action to ensure medications were correctly packaged to prevent error in administration for 3 of 22 reportable incidents reviewed. The facility failed to report to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) an undetermined number of incidents in which 1 sampled client (client #3) and 1 additional client (client #8) were placed at risk from medication errors when client medications were incorrectly packaged, failed to timely report 1 of 22 reports reviewed involving client #8's tampered medication and failed to document a thorough investigation into incidents of tampered or incorrectly packaged medication for clients (#3 and #8).</p>	W000122	<p>W122 The facility must ensure that specific client protections requirements are met. Cardinal Services, Inc. strives to meet and be in compliance with all of the conditions of participation established by the Secretary of Health and Human Services. This allegation of compliance is intended to show Cardinal Services' commitment to quality delivery of services. Proactive strategies and corrective action will be developed as needed to avoid further incidents. It is Cardinal Services' belief that the corrective action taken by management staff and the QMRP has resolved the problems created by the condition out of compliance. Please see W149 Please see W153 Please see W154 Please see W157</p>	09/19/2013			

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	<p>Findings include:</p> <p>1. Please see W149. The facility neglected to implement policy and procedures to protect 1 of 4 sampled clients (client #4) and 2 additional clients (clients #6 and #8) from harm by failing to administer medications per physician's orders for 2 of 22 reportable incidents reviewed and failed for 1 of 4 sampled clients (client #2) and 1 additional client (client #8) to implement effective corrective action to ensure medications were correctly packaged to prevent error in administration for 3 of 22 reportable incidents reviewed. The facility failed to report to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) an undetermined number of incidents in which 1 sampled client (client #3) and 1 additional client (client #8) were placed at risk from medication errors when client medications were incorrectly packaged, failed to timely report 1 of 22 reports reviewed involving client #8's tampered medication and failed to document a thorough investigation into incidents of tampered or incorrectly packaged medication for clients (#3 and #8).</p> <p>2. Please see W153. The facility failed</p>			
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	<p>for 1 sampled client (client #3), and one additional client (client #8) to report to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) an undetermined number of incidents in which clients were placed at risk from medication errors when client medications were incorrectly packaged, and failed to timely report 1 of 22 reports reviewed involving client #8's tampered medication.</p> <p>3. Please see W154. The facility failed to document a thorough investigation into incidents of tampered or incorrectly packaged medication for 1 of 4 sampled clients (client #3), and 1 additional client (client #8).</p> <p>4. Please see W157. The facility failed for 2 of 4 sampled clients (clients #2 and #3), and for 1 additional client (client #8) to implement effective corrective action to ensure medications were administered without error and correctly packaged to prevent error in administration.</p> <p>9-3-2(a)</p>				

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W000149	<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.</p> <p>Based on record review and interview, the facility neglected to implement policy and procedures to protect 1 of 4 sampled clients (client #4) and 2 additional clients (clients #6 and #8) by failing to administer medications per physician's orders for 2 of 22 reportable incidents reviewed and failed for 1 of 4 sampled clients (client #2) and 1 additional client (client #8) to implement effective corrective action to ensure medications were correctly packaged to prevent error in administration for 3 of 22 reportable incidents reviewed. The facility failed to report to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) an undetermined number of incidents in which 1 sampled client (client #3) and 1 additional client (client #8) were placed at risk from medication errors when client medications were incorrectly packaged, failed to timely report 1 of 22 reports reviewed involving client #8's tampered medication and failed to document a thorough investigation into incidents of tampered or incorrectly packaged medication for clients (#3 and #8).</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/6/13 at 4:35 PM and included the following:</p> <p>1. A BDDS report dated 4/8/13 indicated client #4 was given another client's Tramadol (narcotic prescription pain reliever) 100 mg (milligrams) in error. The report indicated the nurse was notified</p>	W000149	W149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Staff had been instructed to complete two person medication passes following a medication error that occurred on April 8, 2013. After two months of completing error free medication passes the manager advised staff they would no longer be required to complete two person medication passes. Medication errors began to occur once again and on July 1, 2013, staff received formal training reinstating the two person medication pass. (See Attachments A and B) On July 10, 2013 staff in the Silver Lake group home received additional training regarding the importance of error free medication administration.(See Attachment C) No additional errors have occurred in the home since June 29, 2013. Cardinal Services takes our responsibility to ensure for the safety of those we support seriously. Once it became evident that staff in the home had tampered with medications, Cardinal Services implemented an aggressive investigation to determine staff involved. The investigation included a drug	09/19/2013			

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	<p>and client #4's vital signs were monitored. Staff were retrained on medication administration and would not be permitted to administer medication until able to demonstrate competency as observed by the nurse, residential manager, QDP (Qualified Disabilities Professional), or Residential Coordinator.</p> <p>A BDDS report dated 4/17/13 indicated client #4 did not receive her noon Depakote 250 mg (seizures). The report indicated client #4 was monitored for seizure activity and staff were disciplined and retrained on medication administration. "Staff will not be permitted to pass medications until they are able to demonstrate competency prior to passing medications again."</p> <p>A BDDS report dated 6/19/13 indicated client #6 was given another client's medications. Client #6 was monitored for side effects and staff were disciplined and retrained on medication administration. "Staff will be required to demonstrate competency while being observed by the nurse, Residential Manager, QDP or Residential Coordinator."</p> <p>A BDDS report dated 6/29/13 at 7:30 PM indicated client #8 was given another client's Ranitidine (anti-acid) 300 mg (milligrams), Clozapine (anti-psychotic) 100 mg, Trazodone (anti-depression/anxiety) 50 mg, dicyclomine (bowel problems) 10 mg, sucralfate (stomach inflammation) 1gr (gram). The report indicated staff were to monitor client #8 for adverse reactions and take her vitals every 2 hours for 24 hours. The report indicated staff were retrained and required to demonstrate competency before administering medications again. An investigation dated 6/30/13 was included with the report and indicated staff #10 had given client #8 client #3's medications. The report indicated staff #10 had</p>		<p>screen for each staff, all of which came back with negative results. Medication checks were put in place each shift. In addition, the nurse, Residential Manager and Residential Coordinator completed unannounced medication checks. All medications were found to be correct with punch packs intact during each medication check. Corrective actions that were put into place prevented staff from tampering with medications in the group home. On July 12, 2013 a dose of medication was missing. An investigation was completed and staff suspected of involvement in medication tampering was suspended and ultimately terminated. In addition to previous noted corrective actions, Cardinal Services has purchased a video monitoring device to monitor medication handling and administration in this location. Electronic monitoring is active on the south side of the home effective September 6, 2013. The target date for the monitoring system on the north side of the home to be active is September 19, 2013. To Ensure that all medication that comes into the home is correctly packaged, will be administered according to the physician's order and does not pose a potential threat to the people living in Cardinal Services' Residential Program a Medication Check-In Procedure was created that</p>				

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	<p>client #8 in the medication area, but put her medications away to check on another client. When staff #10 returned to medication administration, she gave client #8 client #3's medications. The investigation included corrective actions which indicated staff were not to be distracted during administration of medication, to consider harsher discipline for serious errors, and staff #10 had been retrained on medication administration.</p> <p>A BDDS report dated 6/30/13 at 1:00 PM indicated client #8 was taken to the hospital when she was lethargic and given IV (intravenous fluids) to flush the medications (given in error on 6/29/13) from her system. The report indicated client #8 would follow up with her primary care physician (PCP). A follow up report dated 7/11/13 indicated client #8 followed up with her PCP with no further follow up needed. The report indicated there would now be a two person medication administration process to be implemented in the group home with "One staff will administer medication while the second completes a check off list of each step of the medication pass procedure to ensure that no step is omitted and errors do not occur."</p> <p>An investigation dated 4/10/13 for the error on 4/8/13 involving client #4 was reviewed on 8/7/13 at 3:56 PM. The conclusion indicated staff #5 had been distracted by client #8 crying out and had that client on her mind when she gave client #4 client #8's medication. The investigation indicated as corrective action staff assigned to administer medication should not be pulled to another task. The investigation indicated this error occurred on the first day of the two person administration implemented..</p> <p>An investigation dated 4/18/13 regarding the</p>		<p>includes a Check-in List. (See Attachments D and E) Staff in the Silver Lake group home will be trained regarding this procedure by Monday September 9, 2013. To assure that this deficient practice is corrected agency-wide, staff in all locations will receive training regarding this procedure by Thursday September 19, 2013. Training specific to medication storage was written stating that all medication that comes into the home including both client and staff medication, must be secured and stored in a locked closet or cabinet. (See Attachments F and G) Staff in the Silver Lake group home will receive this training by Monday September 9, 2013. To assure that this deficient practice is corrected agency-wide, staff in all locations will receive training regarding this procedure by Thursday September 19, 2013. In addition to assure that current staff and staff that will join the agency in the future are fully trained and aware of Cardinal Services' standards, the Cardinal Services Safety Manual will be updated by September 19, 2013 to include the expectation regarding medication storage. (See Attachment H) The Medication Policy will be revised to include the Medication Check-In Procedure by September 19, 2013. (See Attachment I) All staff will be trained on the manual and policy</p>				

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	<p>medication error for client #4 on 4/17/13 was reviewed on 8/17/13 at 4:06 PM. The conclusion of the investigation indicated staff #5 had not followed medication procedures when she administered the medication and staff #2 had not checked the medications completely as directed in medication administration training.</p> <p>The RC was interviewed on 8/8/13 at 1:30 PM and indicated the facility had failed to prevent medication errors despite their corrective action to implement a two person check during medication administration.</p> <p>2. A BDDS report dated 4/8/13 indicated on 4/6/13 staff "noted that [client #8's] Tramadol punch pack contained several doses of Tylenol rather than Tramadol. Staff immediately contacted the Residential Manager and Nurse. The pharmacy owners were contacted and medications were replaced. On Monday, April 8, 2013 at approximately 8:00 AM, it was discovered that two of the doses of Tylenol in the punch pack had been tampered with in that the edges of the tablet had been trimmed down and the identification number had been partially shaved off. The police were notified and an internal investigation was begun immediately. All staff working in this location are being required to submit to drug screen and and are being questioned as part of an internal investigation." The report indicated a two person medication administration process was being implemented to ensure no medications were being administered unobserved until the investigation was completed.</p> <p>An investigation dated 4/8/13 by the Residential Coordinator (RC) attached to the report indicated a conclusion "It is my conclusion that a staff in the group home altered the medication Tylenol to make it look like Tramadol, possibly to sell the</p>		<p>revisions by September 19, 2013. (See Attachments H and I) The Safety Manual revision will also be included as part of the Employee Handbook in the new fiscal year when the board approves updates. Training is also being provided so that staff recognizes when to report discrepancies with medications and/or medications left unattended. All staff will receive this training by September 19, 2013. (See Attachments D and F) To ensure that all investigations are completed timely and thoroughly Cardinal Services' Residential Managers and Residential Coordinators received training regarding the protocol to follow in the event that on ongoing investigation is turned over to other authorities. (See Attachment J) In addition, Cardinal Services is coordinating a training regarding the investigation procedure through IDSH to be conducted October 23, 2013. To ensure this deficiency does not occur again, the Residential Manager, QDP, Nurse and Residential Coordinator will monitor the administration and storage of medications through weekly, monthly and quarterly written observations. (See attachment K) QMRP, Residential Manager, Nurse and Residential Coordinator Responsible.</p>				

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	<p>medication. The reason is not known. Cardinal Services has not been able to determine who is responsible for this altered medication." The report indicated the police would be conducting an investigation.</p> <p>Statements in the investigation included the following:</p> <p>A statement dated 4/9/13 indicated the Residential Manager (RM) stated "There were problems with packaging three or four times. We were told there were problems with [pharmacy] packaging but [pharmacy] found where the mistake was coming from and they fixed it we thought." The RM stated the replacement medications were placed in the medication room and "when they're checked in, we lock them in the med closet."</p> <p>A statement dated 4/8/13 indicated staff #3 stated, "I've heard about that [staff #14] finds it on weekends. [Client #3] was supposed to get Trazodone, but was getting Tylenol a long time ago. This weekend, it looks like pills had been altered. [Staff #14] wrote that it looked like [client #8's] pill had been altered. It's just weird how it happens on weekends. We check our pills."</p> <p>A statement dated 4/8/13 indicated staff #4 stated, "I thought it was the 2nd time that [pharmacy] messed up but found out it was the 3rd time. I was hit with that just as soon as I walked in, that pills were messed up. [Pharmacy] was contacted."</p> <p>A statement dated 4/8/13 indicated staff #5 stated when asked about tampered medications, "We have one in the office (Tylenol that staff can use) if we need it it's in a drawer...No, it's not locked up."</p> <p>A statement dated 4/8/13 indicated staff #2 stated</p>			

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	<p>when asked about incorrect medication packaging, "I found 'em once. Tramadol, the 5:00 AM med. It was bigger than the other med. I went to [staff #7] and told her. It's been a while back. The 2nd time we found the meds. There was (sic) the wrong meds in the punch pack. [Staff #7] took them back to [pharmacy] and they took care of it."</p> <p>A statement dated 4/8/13 indicated staff #11 stated, "I think this might be the 5th time it has happened. In the past the pills Tramadol, Acetaminophen and Trazodone have been mixed up by [pharmacy] over the past few months. These are [clients #8 and #3's] meds. I don't know how it happens. I'm not sure what's happening that it's not getting caught by [pharmacy]...This past (recent) incident meds were obviously changed. The numbers were scraped off and the edges were cut down. The meds were taken back to [pharmacy] and they found other errors. Fresh packs were sent to the house. Then several weeks later a new punch pack was sent and more Tylenol was found in it."</p> <p>A statement dated 4/8/13 indicated staff #14 stated when asked where the "cycle" (re-filled prescription) medications are stored, "They are not locked up, they are kept in a tub in the linen closet." She stated, "There was a series of events leading up to discovering the first time this happened. I first noticed that [client #8] was acting different." The report indicated "In hindsight, [staff #14] feels [client #8] was in pain because she was not getting her correct pain meds." When asked about her knowledge of anyone who tampered or may have tampered with the medications, she stated, "About a month ago a dose (2 pills) of [client #3's] Trazodone..went missing." Staff #14 indicated she reported it to staff #11 who reported it to the RM.</p>						

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	<p>The investigation did not include why re-filled medications were not locked and did not include corrective steps to ensure medications were secured. There was no investigation provided regarding the previous incidents of incorrectly packaged medications found prior to 4/6/13 as indicated by staff #3, #4, #5, #11 and #14 in their statements.</p> <p>A BDDS report dated 6/8/13 indicated Trazodone pills of client #8 were found in Tramadol punch packs. The Residential Manager and the nurse were notified. Client #8 received her medication as ordered and new medications were being obtained from the pharmacy. The police were notified "to assure no tampering was done to pill packs...Two person med passes are to be done at each med pass until otherwise notified for all staff to assure safety of all residents." A follow up report dated 6/19/13 indicated the drug task force of the police department had "advised Cardinal Services that we had impeded their investigation by having begun our own internal investigation and that if this type of situation occurred in the future, we should allow the task force to investigate rather than attempting to conduct our own investigation." The report indicated video monitoring was in the process of being implemented to monitor staff access to medications, and the facility would address any findings of the police investigation when it was available. A follow up report dated 6/26/13 indicated the video monitoring system would arrive by June 28, 2013. The report indicated daily medication checks would continue until the video monitoring system was in place.</p> <p>A BDDS report dated 7/12/13 indicated at 7:00 AM, a dose of Keppra (seizures) was missing from client #2's medication pack. Client #2 received her medication as ordered. Staff immediately</p>				

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	<p>contacted the on-call supervisor and the Nurse. "Medications are being monitored very closely in this home due to recent concerns regarding medications being tampered with. All medications were counted and confirmed in the home at 3:00 PM on Thursday, June 11, 2013. The police department was contacted and was going to interview staff #14, "the only staff member that has been present and a part of each medication concern was working 12:00 AM -6:30 AM. [Police department] will be meeting with and interviewing [staff #14] at 6:00 PM today, July 12, 2013." The report indicated staff #14 would not be permitted to work until Cardinal Services is confident that she is not involved in tampering with client medications." An updated follow up report indicated "Investigators stated that while this staff (staff #14) would not confess they believed that she was involved," and indicated staff #14 had been terminated. A video system had been installed and was in the process of being implemented but was not fully operational. "Until that time staff is not permitted to pass medications unobserved. Medication counts and checks are completed randomly so that staff does not know when a check will be done...."</p> <p>An investigation dated 6/8/13 into the incident dated 6/8/13 for client #8's medication was reviewed on 8/6/13 at 4:50 PM. The investigation indicated "This incident was handed to police/Drug task force per instructions of police. In the past incidents Cardinal began an immediate investigation that impeded the police investigation. Police notes will be attached once received. Police believe [staff #14] responsible, but she will not</p>			

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	<p>confess." The investigation indicated the facility would increase monitoring, completing medication audits each shift by the RM, QDP, nurse and RC. "Hidden camera installed-IT (information technology) working out glitches. A 7/12/13 note indicated "Missing dose of Keppra in [client #2's] punch pack. [Staff #14] working again. Called police. They interviewed her again. Said she won't confess, but they are convinced she's involved. Suspended and ultimately terminated."</p> <p>The RC was interviewed on 8/8/13 at 11:20 AM and indicated staff #14 had been terminated as she was suspected of tampering with medications. She indicated the police investigation had not been provided despite requests to provide it by the facility.</p> <p>The RC was interviewed again on 8/8/13 at 1:30 PM. She indicated they had not reported the incidents of previous medications that were not correctly packaged prior to 4/8/13 as they thought it was an issue with the pharmacy. She stated, "In hindsight" the potential of receiving the wrong medications had put clients at risk, and the report regarding client #8's tampered medication on 4/6/13 had been reported late. She indicated the steps the facility had put into place had not prevented the medications to be tampered with or incorrectly packaged.</p> <p>The RC was interviewed on 8/9/13 at 10:40 AM and stated, she was unaware the practice of leaving re-filled medications unlocked in the home was "a common practice" until it was brought to</p>						

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	<p>the attention of the HM. She indicated it was in violation of the facility's medication administration policy and procedures and was now corrected.</p> <p>Cardinal Services, Inc. Medication Policy dated 2/13 was reviewed on 8/8/13 at 1:28 PM and indicated medications were to be given without error, including "Incorrect person receiving medication; incorrect medication administered,...Drugs shall be stored in the locked medicine cabinet under proper conditions of sanitation, temperature, moisture, ventilation and segregation...."</p> <p>The facility's policy and procedures "Cardinal Services, Inc. Incident/Abuse/Neglect Policy Persons Served dated 5/13 was reviewed on 8/6/13 at 4:30 PM and indicated in part, "Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental sexual abuse, or exploitation of persons served by staff members, other persons served, or others will not be tolerated; incidents will be reported and thoroughly investigated...." Neglect was defined as "Incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his or her life or health, depriving a person served of necessary support, including...medical care or treatment...", and "The respective Department Head, Service Coordinators, or Case Manager will conduct any investigation, take appropriate action...."</p> <p>9-3-2(a)</p>			

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W000153	<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 for 1 of 4 sampled clients (client #3), and one additional client (client #8) to report to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) an undetermined number of incidents in which clients were placed at risk from medication errors when client medications were incorrectly packaged, and failed to timely report 1 of 22 reports reviewed involving client #8's tampered medication in accordance with state law.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/6/13 at 4:35 PM and included the following:</p> <p>A BDDS report dated 4/8/13 indicated on 4/6/13 staff "noted that [client #8's] Tramadol punch pack contained several doses of Tylenol rather than Tramadol.</p>	W000153	<p>W153 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. Cardinal Services, Inc. is committed to providing quality services and a safe environment free from abuse, neglect and mistreatment for the people that we provide supports for. Cardinal Services, Inc. ensures that staff are trained regarding the BDDS Incident Reporting Procedures and Medication Administration upon new hire and annually thereafter. To assure that staff recognizes when to report discrepancies with medications and/or medications left unattended additional training was created for staff. All staff will receive this training by September 19, 2013. (See Attachments D and F) The QDP, Residential Manager, Nurse and Residential Coordinator will continue to monitor the storage and administration of medications through weekly, monthly and quarterly observations to ensure</p>	09/19/2013	

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	<p>Staff immediately contacted the Residential Manager and Nurse. The pharmacy owners were contacted and medications were replaced. On Monday, April 8, 2013 at approximately 8:00 AM, it was discovered that two of the doses of Tylenol in the punch pack had been tampered with in that the edges of the tablet had been trimmed down and the identification number had been partially shaved off. The police were notified and an internal investigation was begun immediately."</p> <p>Statements in the investigation attached to the report included the following:</p> <p>A statement dated 4/9/13 indicated the Residential Manager (RM) stated "There were problems with packaging three or four times. We were told there were problems with [pharmacy] packaging but [pharmacy] found where the mistake was coming from and they fixed it we thought."</p> <p>A statement dated 4/8/13 indicated staff #3 stated, "I've heard about that [staff #14] finds it on weekends. [Client #3] was supposed to get Trazodone, but was getting Tylenol a long time ago. This weekend, it looks like pills had been altered. [Staff #14] wrote that it looked like [client #8's] pill had been altered. It's</p>		<p>this deficiency does not occur again in the future. Cardinal Services will continue to provide annual training for all staff to assure they are confident in knowing when to report concerns immediately to the on call supervisor. QDP, Residential Manager, Nurse and Residential Coordinator Responsible.</p>				

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	<p>just weird how it happens on weekends. We check our pills."</p> <p>A statement dated 4/8/13 indicated staff #4 stated, "I thought it was the 2nd time that [pharmacy] messed up but found out it was the 3rd time. I was hit with that just as soon as I walked in, that pills were messed up. [Pharmacy] was contacted."</p> <p>A statement dated 4/8/13 indicated staff #2 stated when asked about incorrect medication packaging, "I found 'em once. Tramadol, the 5:00 AM med. It was bigger than the other med (unidentified client's medication). I went to [staff #7] and told her. It's been a while back. The 2nd time we found the meds. There was (sic) the wrong meds in the punch pack (unidentified client's medication). [Staff #7] took them back to [pharmacy] and they took care of it."</p> <p>A statement dated 4/8/13 indicated staff #11 stated, "I think this might be the 5th time it has happened. In the past the pills Tramadol, Acetaminophen and Trazodone have been mixed up by [pharmacy] over the past few months. These are [clients #8 and #3's] meds. I don't know how it happens. I'm not sure what's happening that it's not getting caught by [pharmacy]... This past (recent) incident meds were obviously changed. The</p>						

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	<p>numbers were scraped off and the edges were cut down. The meds were taken back to [pharmacy] and they found other errors. Fresh packs were sent to the house. Then several weeks later a new punch pack was sent and more Tylenol was found in it."</p> <p>A statement dated 4/8/13 indicated staff #14 stated "About a month ago a dose (2 pills) of [client #3's] Trazodone..went missing." Staff #14 indicated she reported it to staff #11 who reported it to the RM (Residential Manager).</p> <p>There was no evidence the incidents of incorrect packaging prior to the incident on 4/8/13 had been reported to the administrator or to BDDS.</p> <p>The RC (Residential Coordinator) was interviewed on 8/8/13 at 1:30 PM. She indicated the incident on 4/6/13 regarding tampered medication had not been reported until 4/8/13 and was late, and they had not reported the incidents of previous medications that were not correctly packaged as they thought it was an issue with the pharmacy. She stated, "In hindsight" the potential of receiving the wrong medications had put clients at risk and should have been reported.</p> <p>9-3-2(a)</p>						

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to document a thorough investigation into incidents of tampered or incorrectly packaged medication for 1 of 4 sampled clients (client #3), and 1 additional client (client #8).</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/6/13 at 4:35 PM and included the following:</p> <p>1. A BDDS report dated 4/8/13 indicated on 4/6/13 staff "noted that [client #8's] Tramadol punch pack contained several doses of Tylenol rather than Tramadol. Staff immediately contacted the Residential Manager and Nurse. The pharmacy owners were contacted and medications were replaced. On Monday, April 8, 2013 at approximately 8:00 AM, it was discovered that two of the doses of Tylenol in the punch pack had been tampered with in that the edges of the tablet had been trimmed down and the identification number had been partially shaved off. The police were notified and an internal investigation was begun immediately. All staff working in this location are being required to submit to drug screen and are being questioned as part of an internal investigation." The report indicated to a two person medication administration process was being implemented to ensure no medications were being administered unobserved until the</p>	W000154	W154 The facility must have evidence that all alleged violations are thoroughly investigated. To ensure that all investigations are completed timely and thoroughly Cardinal Services' Residential Managers and Residential Coordinators received training regarding the protocol to follow in the event that on ongoing investigation is turned over to other authorities. (See Attachment J) In addition, Cardinal Services is coordinating a training regarding the investigation procedure through IDSH to be conducted October 23, 2013. To assure ongoing compliance the Residential Coordinator and Adult Services Director will monitor investigations by ongoing review.	09/19/2013			

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	<p>investigation was completed.</p> <p>An investigation dated 4/8/13 by the Residential Coordinator (RC) attached to the report indicated a conclusion "It is my conclusion that a staff in the group home altered the medication Tylenol to make it look like Tramadol, possibly to sell the medication. The reason is not known. Cardinal Services has not been able to determine who is responsible for this altered medication." The report indicated the police would be conducting an investigation.</p> <p>Statements in the investigation included the following:</p> <p>A statement dated 4/9/13 indicated the house manager (HM) stated "There were problems with packaging three or four times. We were told there were problems with [pharmacy] packaging but [pharmacy] found where the mistake was coming from and they fixed it we thought." The HM stated the replacement medications were placed in the medication room and "when they're checked in, we lock them in the med closet."</p> <p>A statement dated 4/8/13 indicated staff #3 stated, "I've heard about that [staff #14] finds it on weekends. [Client #3] was supposed to get Trazodone, but was getting Tylenol a long time ago. This weekend, it looks like pills had been altered. [Staff #14] wrote that it looked like [client #8's] pill had been altered. It's just weird how it happens on weekends. We check our pills."</p> <p>A statement dated 4/8/13 indicated staff #4 stated, "I thought it was the 2nd time that [pharmacy] messed up but found out it was the 3rd time. I was hit with that just as soon as I walked in, that pills were messed up. [Pharmacy] was contacted."</p>						

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	<p>A statement dated 4/8/13 indicated staff #5 stated when asked about tampered medications, "We have one in the office (Tylenol that staff can use) if we need it it's in a drawer..."No, it's not locked up."</p> <p>A statement dated 4/8/13 indicated staff #2 stated when asked about incorrect medication packaging, "I found 'em once. Tramadol, the 5:00 AM med. It was bigger than the other med. I went to [staff #7] and told her. It's been a while back. The 2nd time we found the meds. There was (sic) the wrong meds in the punch pack. [Staff #7] took them back to [pharmacy] and they took care of it."</p> <p>A statement dated 4/8/13 indicated staff #11 stated, "I think this might be the 5th time it has happened. In the past the pills Tramadol, Acetaminophen and Trazodone have been mixed up by [pharmacy] over the past few months. These are [clients #8 and #3's] meds. I don't know how it happens. I'm not sure what's happening that it's not getting caught by [pharmacy]...This past (recent) incident meds were obviously changed. The numbers were scraped off and the edges were cut down. The meds were taken back to [pharmacy] and they found other errors. Fresh packs were sent to the house. Then several weeks later a new punch pack was sent and more Tylenol was found in it."</p> <p>A statement dated 4/8/13 indicated staff #14 stated when asked where the "cycle" (re-filled prescription) medications are stored, "They are not locked up, they are kept in a tub in the linen closet." She stated, "There was a series of events leading up to discovering the first time this happened. I first noticed that [client #8] was acting different." The report indicated "In hindsight, [staff #14] feels [client #8] was in pain because she was not getting her correct pain meds." When</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G694	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 10381 S SR 15 SILVER LAKE, IN 46982
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	<p>asked about her knowledge of anyone who tampered or may have tampered with the medications, she stated, "About a month ago a dose (2 pills) of [client #3's] Trazodone..went missing." Staff #14 indicated she reported it to staff #11 who reported it to the HM.</p> <p>The investigation did not include why re-filled medications were not locked and did not include corrective steps to ensure medications were secured, and did not indicate an investigation had been completed regarding the previous incidents prior to 4/6/13 where client medications had been found incorrectly packaged.</p> <p>The RC was interviewed on 8/8/13 at 11:20 AM and indicated the police investigation had not been provided despite requests to provide it by the facility.</p> <p>The RC was interviewed again on 8/8/13 at 1:30 PM. She indicated they had not reported the incidents of previous medications that were not correctly packaged as they thought it was an issue with the pharmacy. She stated, "In hindsight" the potential of receiving the wrong medications had put clients at risk, but had not conducted an investigation into the incidents of incorrectly packaged medications.</p> <p>The RC was interviewed on 8/9/13 at 10:40 AM and stated, she was unaware the practice of leaving re-filled medications unlocked in the home was "a common practice" until it was brought to the attention of the HM. She indicated it was in violation of the facility's medication administration policy and procedures and was now corrected, but had not been addressed in the investigation.</p> <p>9-3-2(a)</p>			

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 10381 S SR 15 SILVER LAKE, IN 46982			
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W000157	<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 record review and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #3), and for 2 additional clients (clients #6 and #8) to implement effective corrective action to ensure medications were administered without error and correctly packaged to prevent error in administration.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/6/13 at 4:35 PM and included the following:</p> <p>1. A BDDS report dated 4/8/13 indicated client #4 was given another client's Tramadol (narcotic prescription pain reliever) 100 mg (milligrams) in error. The report indicated staff were retrained on medication administration and would not be permitted to administer medication until able to demonstrate competency as observed by the nurse, Residential Manager (RM), QDP (Qualified Disabilities Professional), or Residential Coordinator (RC).</p>	W000157	W157 If the alleged violation is verified, appropriate corrective action must be taken. Staff had been instructed to complete two person medication passes following a medication error that occurred on April 8, 2013. After two months of completing error free medication passes the manager advised staff they would no longer be required to complete two person medication passes. Medication errors began to occur once again and on July 1, 2013, staff received formal training reinstating the two person medication pass. (See Attachments A and B) On July 10, 2013 staff in the Silver Lake group home received additional training regarding the importance of error free medication administration.(See Attachment C) No additional errors have occurred in the home since June 29, 2013. Once it became evident that staff in the home had tampered with medications, Cardinal Services implemented an aggressive investigation to determine staff involved. The investigation included a drug screen for each staff, all of which came back with negative results. Medication checks were put in place each shift. In addition, the nurse, Residential Manager and Residential Coordinator	09/19/2013			

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 10381 S SR 15 SILVER LAKE, IN 46982			
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	<p>A BDDS report dated 4/17/13 indicated client #4 did not receive her noon Depakote 250 mg (seizures). The report indicated client #4 was monitored for seizure activity and staff were disciplined and retrained on medication administration. "Staff will not be permitted to pass medications until they are able to demonstrate competency prior to passing medications again."</p> <p>A BDDS report dated 6/19/13 indicated client #6 was given another client's medications. Client #6 was monitored for side effects and staff were disciplined and retrained on medication administration. "Staff will be required to demonstrate competency while being observed by the nurse, Residential Manager, QDP, or Residential Coordinator."</p> <p>A BDDS report dated 6/29/13 at 7:30 PM indicated client #8 was given another client's Ranitidine (anti-acid) 300 mg (milligrams), Clozapine (anti-psychotic) 100 mg, Trazodone (anti-depression/anxiety) 50 mg, dicyclomine (bowel problems) 10 mg, sucralfate (stomach inflammation) 1gr (gram). The report indicated staff were to monitor client #8 for adverse reactions and take her vitals every 2 hours for 24 hours. The report indicated staff were retrained and required to demonstrate</p>		<p>completed unannounced medication checks. All medications were found to be correct with punch packs intact during each medication check. Corrective actions that were put into place prevented staff from tampering with medications in the group home. On July 12, 2013 a dose of medication was missing. An investigation was completed and staff suspected of involvement in medication tampering was suspended and ultimately terminated. In addition to previous noted corrective actions, Cardinal Services has purchased a video monitoring device to monitor medication handling and administration in this location. Electronic monitoring is active on the south side of the home effective September 6, 2013. The target date for the monitoring system on the north side of the home to be active is September 19, 2013. To Ensure that all medication that comes into the home is correctly packaged, will be administered according to the physician's order and does not pose a potential threat to the people living in Cardinal Services' Residential Program a Medication Check-In Procedure was created that includes a Check-in List. (See Attachments D and E) Staff in the Silver Lake group home will be trained regarding this procedure by Monday September 9, 2013. To assure that this</p>				

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 10381 S SR 15 SILVER LAKE, IN 46982			
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	<p>competency before administering medications again. The investigation indicated corrective actions of staff were not to be distracted during administration of medication, to consider harsher discipline for serious errors, and staff #10 had been retrained on medication administration.</p> <p>A BDDS report dated 6/30/13 at 1:00 PM indicated client #8 was taken to the hospital when she was lethargic and given IV (intravenous fluids) to flush the medications (given in error on 6/29/13) from her system. The report indicated client #8 would follow up with her primary care physician (PCP). A follow up report dated 7/11/13 indicated client #8 followed up with her PCP with no further follow up needed. The report indicated there would now be a two person medication administration process to be implemented in the group home with "One staff will administer medication while the second completes a check off list of each step of the medication pass procedure to ensure that no step is omitted and errors do not occur."</p> <p>An investigation dated 4/10/13 for the error on 4/8/13 involving client #4 was reviewed on 8/7/13 at 3:56 PM. The conclusion indicated staff #5 had been</p>		<p>deficient practice is corrected agency-wide, staff in all locations will receive training regarding this procedure by Thursday September 19, 2013. To ensure this deficiency does not occur again, the Residential Manager, QDP, Nurse and Residential Coordinator will monitor the administration and storage of medications through weekly, monthly and quarterly written observations. (See attachment K) Residential Nurse, QMRP and Residential Manager Responsible</p>				

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	<p>distracted by client #8 crying out and had that client on her mind when she gave client #4 client #8's medication. The investigation indicated as corrective action staff assigned to administer medication should not be pulled to another task. The investigation indicated this error occurred on the first day of the two person administration implemented..</p> <p>An investigation dated 4/18/13 regarding the medication error for client #4 on 4/17/13 was reviewed on 8/17/13 at 4:06 PM. The conclusion of the investigation indicated staff #5 had not followed medication procedures when she administered the medication and staff #2 had not checked the medications completely as directed in medication administration training.</p> <p>The RC was interviewed on 8/8/13 at 1:30 PM and indicated the facility had failed to prevent medication errors despite their corrective actions to implement a two person check during medication administration and retrain staff.</p> <p>2. A BDDS report dated 4/8/13 indicated on 4/6/13 staff "noted that [client #8's] Tramadol punch pack contained several doses of Tylenol rather than Tramadol. Staff immediately contacted the Residential Manager and Nurse. The</p>			

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	<p>pharmacy owners were contacted and medications were replaced. On Monday, April 8, 2013 at approximately 8:00 AM, it was discovered that two of the doses of Tylenol in the punch pack had been tampered with in that the edges of the tablet had been trimmed down and the identification number had been partially shaved off. The police were notified and an internal investigation was begun immediately. All staff working in this location are being required to submit to drug screen and are being questioned as part of an internal investigation." The report indicated a two person medication administration process was being implemented to ensure no medications were being administered unobserved until the investigation was completed.</p> <p>An investigation dated 4/8/13 by the RC attached to the report indicated a conclusion "It is my conclusion that a staff in the group home altered the medication Tylenol to make it look like Tramadol, possibly to sell the medication. The reason is not known. Cardinal Services has not been able to determine who is responsible for this altered medication." The report indicated the police would be conducting an investigation.</p> <p>Statements in the investigation included</p>			

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	<p>the following:</p> <p>A statement dated 4/9/13 indicated the RM stated "There were problems with packaging three or four times. We were told there were problems with [pharmacy] packaging but [pharmacy] found where the mistake was coming from and they fixed it we thought." The HM stated the replacement medications were placed in the medication room and "when they're checked in, we lock them in the med closet."</p> <p>A statement dated 4/8/13 indicated staff #3 stated, "I've heard about that [staff #14] finds it on weekends. [Client #3] was supposed to get Trazodone, but was getting Tylenol a long time ago. This weekend, it looks like pills had been altered. [Staff #14] wrote that it looked like [client #8's] pill had been altered. It's just weird how it happens on weekends. We check our pills."</p> <p>A statement dated 4/8/13 indicated staff #4 stated, "I thought it was the 2nd time that [pharmacy] messed up but found out it was the 3rd time. I was hit with that just as soon as I walked in, that pills were messed up. [Pharmacy] was contacted."</p> <p>A statement dated 4/8/13 indicated staff #5 stated when asked about tampered</p>			

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	<p>medications, "We have one in the office (Tylenol that staff can use) if we need it it's in a drawer..."No, it's not locked up."</p> <p>A statement dated 4/8/13 indicated staff #2 stated when asked about incorrect medication packaging, "I found 'em once. Tramadol, the 5:00 AM med. It was bigger than the other med. I went to [staff #7] and told her. It's been a while back. The 2nd time we found the meds. There was (sic) the wrong meds in the punch pack. [Staff #7] took them back to [pharmacy] and they took care of it."</p> <p>A statement dated 4/8/13 indicated staff #11 stated, "I think this might be the 5th time it has happened. In the past the pills Tramadol, Acetaminophen and Trazodone have been mixed up by [pharmacy] over the past few months. These are [clients #8 and #3's] meds. I don't know how it happens. I'm not sure what's happening that it's not getting caught by [pharmacy]...This past (recent) incident meds were obviously changed. The numbers were scraped off and the edges were cut down. The meds were taken back to [pharmacy] and they found other errors. Fresh packs were sent to the house. Then several weeks later a new punch pack was sent and more Tylenol was found in it."</p>			

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 10381 S SR 15 SILVER LAKE, IN 46982		
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	<p>A statement dated 4/8/13 indicated "In hindsight, [staff #14] feels [client #8] was in pain because she was not getting her correct pain meds." When asked about her knowledge of anyone who tampered or may have tampered with the medications, she stated, "About a month ago a dose (2 pills) of [client #3's] Trazodone..went missing." Staff #14 indicated she reported it to staff #11 who reported it to the RM.</p> <p>The investigation did not include why re-filled medications were not locked and did not include corrective steps to ensure medications were secured.</p> <p>A BDDS report dated 6/8/13 indicated Trazodone pills of client #8 were found in Tramadol punch packs. The Residential Manager was notified and the nurse was notified. Client #8 received her medication as ordered and new medications were being obtained from the pharmacy. The police were notified "to assure no tampering was done to pill packs...Two person med passes are to be done at each med pass until otherwise notified for all staff to assure safety of all residents." A follow up report dated 6/19/13 indicated the drug task force of the police department had "advised Cardinal Services that we had impeded their investigation by having begun our</p>				

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 10381 S SR 15 SILVER LAKE, IN 46982
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	<p>own internal investigation and that if this type of situation occurred in the future, we should allow the task force to investigate rather than attempting to conduct our own investigation." The report indicated video monitoring was in the process of being implemented to monitor staff access to medications, and the facility would address any findings of the police investigation when it was available. A follow up report dated 6/26/13 indicated the video monitoring system would arrive by June 28, 2013. The report indicated daily medication checks would continue until the video monitoring system was in place.</p> <p>A BDDS report dated 7/12/13 indicated at 7:00 AM, a dose of Keppra (seizures) was missing from client #2's medication pack. Client #2 received her medication as ordered. Staff immediately contacted the on-call supervisor and the Nurse. "Medications are being monitored very closely in this home due to recent concerns regarding medications being tampered with. All medications were counted and confirmed in the home at 3:00 PM on Thursday, June 11, 2013. The police department was contacted and was going to interview staff #14, "the only staff member that has been present and a part of each medication concern was working 12:00 AM -6:30 AM. [Police</p>			

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 10381 S SR 15 SILVER LAKE, IN 46982			
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	<p>department] will be meeting with and interviewing [staff #14] at 6:00 PM today, July 12, 2013." The report indicated staff #14 would not be permitted to work until Cardinal Services is confident that she is not involved in tampering with client medications." An updated follow up report indicated "Investigators stated that while this staff (staff #14) would not confess they believed that she was involved," and indicated staff #14 had been terminated. A video system had been installed and was in the process of being implemented but was not fully operational. "Until that time staff is not permitted to pass medications unobserved. Medication counts and checks are completed randomly so that staff does not know when a check will be done...."</p> <p>An investigation dated 6/8/13 into the incident dated 6/8/13 for client #8's medication was reviewed on 8/6/13 at 4:50 PM. The investigation indicated the facility would increase monitoring, complete medication audits each shift by the RM, QDP, nurse and RC. "Hidden camera installed-IT (information technology) working out glitches. A 7/12/13 note indicated "Missing dose of Keppra in [client #2's] punch pack. [Staff #14] working again. Called police. (Staff #14) Suspended and ultimately</p>						

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	<p>terminated."</p> <p>The RC was interviewed on 8/8/13 at 11:20 AM and indicated staff #14 had been terminated as she was suspected of tampering with medications.</p> <p>The RC was interviewed again on 8/8/13 at 1:30 PM. She indicated they had investigated the incidents of previous medications that were not correctly packaged as they thought it was an issue with the pharmacy. She stated, "In hindsight" the potential of receiving the wrong medications had put clients at risk. She indicated the steps the facility had put into place had not prevented the medications to be tampered with or incorrectly packaged.</p> <p>The RC was interviewed on 8/9/13 at 10:40 AM and stated, she was unaware the practice of leaving re-filled medications unlocked in the home was "a common practice" until it was brought to the attention of the RM. She indicated it was in violation of the facility's medication administration policy and procedures and was now corrected.</p> <p>9-3-2(a)</p>				

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W000340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on record review and interview, the facility's nursing services failed for 1 of 4 sampled clients (client #4), and 2 additional clients (clients #6 and #8) to ensure staff were trained to competency in administering clients' medications without error.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/6/13 at 4:35 PM and included the following:</p> <p>1. A BDDS report dated 4/8/13 indicated client #4 was given another client's Tramadol (narcotic prescription pain reliever) 100 mg (milligrams) in error. The report indicated the nurse was notified and client #4's vital signs were monitored. Staff were retrained on medication administration and would not be permitted to administer medication until able to demonstrate competency as observed by the nurse, residential manager (RM), QDP (Qualified Disabilities Professional), or Residential Coordinator (RC).</p> <p>A BDDS report dated 4/17/13 indicated client #4 did not receive her noon Depakote 250 mg (seizures). The report indicated client #4 was monitored for seizure activity and staff were disciplined and retrained on medication administration. "Staff will not be permitted to pass</p>	W000340	<p>W 340 Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Staff that had committed medication has been instructed to complete Med Recertification training and meet competency no later than Monday September 9, 2013.(See Attachment L) In addition, staff that had two medication errors was required to complete Medication Error Competency Testing and pass with a score of 100% to confirm knowledge of the medication administration procedure. (See Attachment M) Cardinal Services is confident that correction actions have been effective as there has not been a medication error in this location since June 29, 2013. However, to ensure aggressive preventative measures are in place, the Medication Error Policy has been revised to state that if staff commit a preventable medication error, they will be required to pass a written competency test at</p>	09/19/2013	

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	<p>medications until they are able to demonstrate competency prior to passing medications again."</p> <p>A BDDS report dated 6/19/13 indicated client #6 was given another client's medications. Client #6 was monitored for side effects and staff were disciplined and retrained on medication administration. "Staff will be required to demonstrate competency while being observed by the nurse, Residential Manager, QDP or Residential Coordinator."</p> <p>A BDDS report dated 6/29/13 at 7:30 PM indicated client #8 was given another client's Ranitidine (anti-acid) 300 mg (milligrams), Clozapine (anti-psychotic) 100 mg, Trazodone (anti-depression/anxiety) 50 mg, dicyclomine (bowel problems) 10 mg, sucralfate (stomach inflammation) 1gr (gram). The report indicated staff were to monitor client #8 for adverse reactions and take her vitals every 2 hours for 24 hours. The report indicated staff were retrained and required to demonstrate competency before administering medications again. An investigation dated 6/30/13 was included with the report and indicated staff #10 had given client #8 client #3's medications. The report indicated staff #10 had client #8 in the medication area, but put her medications away to check on another client. When staff #10 returned to medication administration, she gave client #8 client #3's medications. The investigation indicated staff were not to be distracted during administration of medication, to consider harsher discipline for serious errors, and staff #10 had been retrained on medication administration.</p> <p>A BDDS report dated 6/30/13 at 1:00 PM indicated client #8 was taken to the hospital when she was lethargic and given IV (intravenous fluids) to flush the medications (given in error on</p>		100% and then complete a full, error free medication administration under observation of the QDP, Residential Manager, Nurse or QDP prior to being permitted to administer medications independently. To ensure this deficiency does not occur again, the Residential Manager, QDP, Nurse and Residential Coordinator will monitor the administration and storage of medications through weekly, monthly and quarterly written observations. (See attachment K)	

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	<p>6/29/13) from her system. The report indicated client #8 would follow up with her primary care physician (PCP). A follow up report dated 7/11/13 indicated client #8 followed up with her PCP with no further follow up needed. The report indicated there would now be a two person medication administration process to be implemented in the group home with "One staff will administer medication while the second completes a check off list of each step of the medication pass procedure to ensure that no step is omitted and errors do not occur."</p> <p>An investigation dated 4/10/13 for the error on 4/8/13 involving client #4 was reviewed on 8/7/13 at 3:56 PM. The conclusion indicated staff #5 had been distracted by client #8 crying out and had that client on her mind when she gave client #4 client #8's medication. The investigation indicated as corrective action staff assigned to administer medication should not be pulled to another task. The investigation indicated this error occurred on the first day of the two person administration implemented..</p> <p>An investigation dated 4/18/13 regarding the medication error for client #4 on 4/17/13 was reviewed on 8/17/13 at 4:06 PM. The conclusion of the investigation indicated staff #5 had not followed medication procedures when she administered the medication and staff #2 had not checked the medications completely as directed in medication administration training.</p> <p>Staff training records for medication administration were reviewed on 8/13/13 at 1:36 PM and indicated staff #4 had been retrained on 4/9/13, staff #5 was retrained on 4/19/13 and again on 6/19/13 when she passed medications to the</p>						

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	<p>wrong client.</p> <p>The RM was interviewed on 8/8/13 at 1:30 PM and indicated the facility had failed to prevent medication errors despite their corrective action to implement a two person check during medication administration, and indicated staff had not implemented training on medication administration procedures to prevent medications errors.</p> <p>9-3-6(a)</p>						

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based upon record review and interview for 1 of 4 sampled clients (client #4), and 2 additional clients (clients #6 and #8), the facility failed to ensure medications were passed as indicated in physician's orders.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/6/13 at 4:35 PM and included the following:</p> <p>1. A BDDS report dated 4/8/13 indicated client #4 was given another client's Tramadol (narcotic prescription pain reliever) 100 mg (milligrams) in error. The report indicated the nurse was notified and client #4's vital signs were monitored. Staff were retrained on medication administration and would not be permitted to administer medication until able to demonstrate competency as observed by the nurse, Residential Manager (RM), QDP (Qualified Disabilities Professional), or Residential Coordinator (RC).</p>	W000368	<p>W368 The system for drug administration must assure that all drugs are administered in compliance with all physician's orders. Staff had been instructed to complete two person medication passes following a medication error that occurred on April 8, 2013. After two months of completing error free medication passes the manager advised staff they would no longer be required to complete two person medication passes. Medication errors began to occur once again and on July 1, 2013, staff received formal training reinstating the two person medication pass. (See Attachments A and B) On July 10, 2013 staff in the Silver Lake group home received additional training regarding the importance of error free medication administration.(See Attachment C) No additional errors have occurred in the home since June 29, 2013. Cardinal Services takes our responsibility to ensure for the safety of those we support seriously. Once it became evident that staff in the home had tampered with medications, Cardinal Services implemented an aggressive investigation to determine staff involved. The investigation included a drug</p>	09/19/2013	

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	<p>A BDDS report dated 4/17/13 indicated client #4 did not receive her noon Depakote 250 mg (seizures). The report indicated client #4 was monitored for seizure activity and staff were disciplined and retrained on medication administration. "Staff will not be permitted to pass medications until they are able to demonstrate competency prior to passing medications again."</p> <p>A BDDS report dated 6/19/13 indicated client #6 was given another client's medications. Client #6 was monitored for side effects and staff were disciplined and retrained on medication administration. "Staff will be required to demonstrate competency while being observed by the nurse, Residential Manager, QDP or Residential Coordinator."</p> <p>A BDDS report dated 6/29/13 at 7:30 PM indicated client #8 was given another client's Ranitidine (anti-acid) 300 mg (milligrams), Clozapine (anti-psychotic) 100 mg, Trazodone (anti-depression/anxiety) 50 mg, dicyclomine (bowel problems) 10 mg, sucralfate (stomach inflammation) 1gr (gram). The report indicated staff were to monitor client #8 for adverse reactions and take her vitals every 2 hours for 24 hours. The report indicated staff were retrained and required to demonstrate</p>		<p>screen for each staff, all of which came back with negative results. Medication checks were put in place each shift. In addition, the nurse, Residential Manager and Residential Coordinator completed unannounced medication checks. All medications were found to be correct with punch packs intact during each medication check. Corrective actions that were put into place prevented staff from tampering with medications in the group home. On July 12, 2013 a dose of medication was missing. An investigation was completed and staff suspected of involvement in medication tampering was suspended and ultimately terminated. In addition to previous noted corrective actions, Cardinal Services has purchased a video monitoring device to monitor medication handling and administration in this location. Electronic monitoring is active on the south side of the home effective September 6, 2013. The target date for the monitoring system on the north side of the home to be active is September 19, 2013. To Ensure that all medication that comes into the home is correctly packaged, will be administered according to the physician's order and does not pose a potential threat to the people living in Cardinal Services' Residential Program a Medication Check-In Procedure was created</p>				

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	<p>competency before administering medications again. An investigation dated 6/30/13 was included with the report and indicated staff #10 had given client #8 client #3's medications. The report indicated staff #10 had client #8 in the medication area, but put her medications away to check on another client. When staff #10 returned to medication administration, she gave client #8 client #3's medications. The investigation indicated staff were not to be distracted during administration of medication, to consider harsher discipline for serious errors, and staff #10 had been retrained on medication administration.</p> <p>A BDDS report dated 6/30/13 at 1:00 PM indicated client #8 was taken to the hospital when she was lethargic and given IV (intravenous fluids) to flush the medications (given in error on 6/29/13) from her system. The report indicated client #8 would follow up with her primary care physician (PCP). A follow up report dated 7/11/13 indicated client #8 followed up with her PCP with no further follow up needed. The report indicated there would now be a two person medication administration process to be implemented in the group home with "One staff will administer medication while the second completes a check off list of each step of the</p>		<p>that includes a Check-in List. (See Attachments D and E) Staff in the Silver Lake group home will be trained regarding this procedure by Monday September 9, 2013. To assure that this deficient practice is corrected agency-wide, staff in all locations will receive training regarding this procedure by Thursday September 19, 2013. To ensure this deficiency does not occur again, the Residential Manager, QDP, Nurse and Residential Coordinator will monitor the administration of medications through weekly, monthly and quarterly written observations. (See attachment K) Residential Manager, Nurse, QDP and Residential Coordinator Responsible.</p>				

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	<p>medication pass procedure to ensure that no step is omitted and errors do not occur."</p> <p>An investigation dated 4/10/13 for the error on 4/8/13 involving client #4 was reviewed on 8/7/13 at 3:56 PM. The conclusion indicated staff #5 had been distracted by client #8 crying out and had that client on her mind when she gave client #4 client #8's medication. The investigation indicated as corrective action staff assigned to administer medication should not be pulled to another task. The investigation indicated this error occurred on the first day of the two person administration implemented.</p> <p>An investigation dated 4/18/13 regarding the medication error for client #4 on 4/17/13 was reviewed on 8/17/13 at 4:06 PM. The conclusion of the investigation indicated staff #5 had not followed medication procedures when she administered the medication and staff #2 had not checked the medications completely as directed in medication administration training.</p> <p>The RC was interviewed on 8/8/13 at 1:30 PM and indicated the facility had failed to prevent medication errors despite their corrective action to implement a two person check during medication</p>			

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