

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/14/2012
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506
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W0000	<p>This visit was for the investigation of complaint #IN00119568.</p> <p>Complaint #IN00119568: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W102, W104, W122, W149, W153, and W157.</p> <p>Dates of Survey: December 5, 6, 7, 10, 11, 12, and 14, 2012</p> <p>Provider Number: 15G632 Facility Number: 001208 AIM Number: 100240170</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/21/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (A and B) and for 1 additional client (client D). The governing body failed to provide oversight and management to prevent abuse, neglect, and/or mistreatment and to implement a written policy and procedure to prevent abuse, neglect, and/or mistreatment of clients B and D by the immediate supervisor. The governing body failed to ensure the facility put in place corrective measures/actions to address abuse, neglect, and/or mistreatment and injuries of unknown origin for clients B and D.</p> <p>Findings include:</p> <p>Please refer to W104. The governing body failed to implement policy and procedure to protect clients from abuse/neglect/mistreatment, to immediately report all allegations of abuse, neglect, mistreatment including supervisors of the facility, and failed to ensure administrative oversight of the facility supervisor to ensure staff supervision for 3 of 8 clients (clients A,</p>	W0102	<p>W102</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>On 12/10/2013 and again on 1/2/2013 Direct Support Professionals were retrained on the agency's Incident/Abuse/Neglect Policy. More specifically, Direct Support Staff were retrained that any suspicion/allegation/witness of abuse, neglect, and mistreatment MUST be reported to that person's supervisor or the on-call supervisor immediately. If the allegations is against staff's direct supervisor or on-call supervisor staff are to follow the chain of command and contact the agency's Coordinator. Staff were retrained on the agency's hierarchy and whom to contact in the event a manager is the perpetrator.</p> <p>On 1/2/2013 the agency updated,</p>	01/13/2013			

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	<p>B, D) who lived in the group home.</p> <p>Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement interventions and provide sufficient supervision to ensure protection of clients to prevent staff abuse, neglect, and mistreatment. The governing body failed to immediately report allegations of staff to client abuse, neglect, mistreatment and injuries of unknown origin to BDDS (Bureau of Developmental Disability Services), and failed to implement sufficient corrective action to prevent abuse, neglect, and mistreatment for 3 of 8 clients (clients A, B, D) living in the facility.</p> <p>This federal tag relates to complaint #IN00119568.</p> <p>9-3-1(a)</p>		<p>and trained staff on, the Incident/Abuse/Neglect Policy under section 5.1, which includes "If allegation involves a person's direct supervisor, or the on-call supervisor, the staff will call that person's immediate supervisor."</p> <p>Furthermore, staff were retrained that the agency is committed to ensuring the safety, dignity, and protection of persons served.</p> <p>Additionally, on 1/2/2013, staff were retrained on the agency's Code of Ethics – section 3A – which states that all staff are required to meet the behavioral expectations requiring staff to work in a manner that supports the Cardinal mission, vision and beliefs. All staff are required to implement and follow an individual's plan, policies/ procedures set forth by the agency, and state/federal regulations.</p> <p>Between the dates of 12/3/12 – 12/8/2012 and again on 1/2/2013 staff were trained on client B's elopement plan stating that staff must be assigned to client B at all times while in the community. Client B is to be no more than an arm's length away.</p>		

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			<p>Between the dates of 11/13/12-11/17/2012 and again on 1/2/2013 staff were trained on client A's updated fall plan. More specifically, staff were trained that a formal assessment of the environment, in conjunction with a review of person served fall plans and/or diagnosis', will be conducted prior to a change in physical environment.</p> <p>The QDP and Residential Manager complete monthly observations in the group home to ensure staff are implementing person served plans, following agency policy/procedure, and state/federal guidelines. The Coordinator completes quarterly reviews in the group home, including paperwork compliance and group home observation.</p> <p>(See attachments A-R)</p> <p>Coordinator, Residential Manager, QDP and Direct Support Professionals responsible</p>		

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W0104	<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 on observation, record review, and interview, for 3 of 8 clients (clients A, B, D) who lived in the group home, the governing body failed to implement policy and procedure to protect clients from abuse/neglect/mistreatment, to immediately report all allegations of abuse, neglect, mistreatment including supervisors of the facility, and to ensure administrative oversight of the facility supervisor.</p> <p>Findings include:</p> <p>On 12/5/12 at 12noon, the facility BDDS (Bureau of Developmental Disability Services) reports and investigations were reviewed for the period of 9/1/12 through 12/5/12 and indicated the following allegations of abuse, neglect, and/or mistreatment:</p> <p>-A BDDS report on 12/3/12 for an incident on 11/29/12 at 4pm, indicated "11/29/12 [client B] went shopping with the Residential Manager (RM). They arrived at [a local large department store] at 3:30 (pm). The [second staff] who drove the RM and client B to the store left them at the store at 3:45pm." The report</p>	W0104	<p>W104 The governing body must exercise general policy, budget, and operating direction over the facility. On 12/10/2012 and 1/2/2013 staff were retrained on the agency's Incident/Abuse/Neglect Policy. More specifically, staff were retrained on types of reportable incidents, the agency's heirarchy and who to report to in the event staff suspect their direct supervisor or on-call manager of abuse/neglect/mistreatment. Furthermore, staff were trained that derogatory comments towards consumers is not tolerated and is reportable per the BDDS Incident reporting guidelines. Cardinal Services updated the Incident/Abuse/Neglect policy to include what staff should do in the event their direct supervisor or on-call manager is involved in the incident. Staff were retrained on the updated policy on 1/2/2013. (See attachments A - T) The QDP and Residential Manager complete monthly observations in the group home to ensure staff are implementing person served plans, following agency policy/procedure, and state/federal guidelines. The Coordinator completes quarterly reviews in the group home,</p>	01/13/2013	

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	<p>indicated the second staff person returned to the store for the RM and client B at "4:10pm and parked the van near the entrance of the store." The second staff had three other clients on the van. The staff texted the RM of their arrival and waited in the van. The report indicated the second staff indicated she "did not get a response" from the RM. The "RM called the [second staff person] and stated that he could not find [client B]. At that time the second staff saw [client B] near the front door with a [store] employee." The report indicated the store employee stated to the staff person that client B was leaving the store alone. The report indicated the store employee had stated to the staff that client B "was without staff...no more than 25 (twenty-five) minutes." The report indicated the RM was suspended on 11/30/12 for "an unrelated incident" and the Residential Coordinator discovered this incident during the investigation of the "unrelated incident."</p> <p>-A BDDS report on 12/4/12 for an incident on 11/19/12 at 5pm, indicated "During an investigation for an unrelated incident the (Residential) Coordinator (RC) learned that the Residential Manager had been joking around with staff and [client D] on 11/19/12. The Residential Manager told [client D] he had a Fat A--.</p>		including paperwork compliance and group home observation. Coordinator, Residential Manager, QDP responsible		

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	<p>Staff stated that [client D] appeared to be upset. The Residential Manager told [client D] I'm just joking with you Buddy. Staff told the Residential Manager that he couldn't joke with [client D]."</p> <p>Observations and interviews were completed at the group home on 12/5/12 from 3:05pm until 4:30pm. At 3:15pm, FS (Facility Staff) #17 stated clients A, B, E, G, and H were non verbal and "none of the clients" recognized dangers or abuse. At 3:15pm, FS #17 stated client B "needed supervision in the community." FS #17 indicated she witnessed client B unsupervised at the department store when client B was left supervised by the RM. FS #17 stated she did not immediately report the incident because the RM was her direct supervisor. FS #17 indicated she reported the 11/29/12 incident before midnight on 11/30/12 by email after the RC had contacted her about the unrelated incident investigation with the RM earlier in the day on 11/30/12. FS #17 indicated she did not immediately report client D's verbal abuse allegation by the RM. At 3:15pm, FS #6 indicated she did not immediately report client D's verbal abuse allegation by the RM. At 3:45pm, FS #5 indicated she did not immediately report client D's verbal abuse allegation by the RM.</p>						

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	<p>On 12/5/12 at 12:40pm, an interview with the QDDP (Qualified Developmental Disability Professional) was conducted. The QDDP indicated he did not have information regarding investigation into the RM incident allegations.</p> <p>On 12/7/12 at 1:40pm, an interview with the RC (Residential Coordinator) was conducted. The RC stated she was in the "process" of staff retraining for abuse, neglect, and mistreatment. The RC stated an investigation was "being completed" for an unrelated incident of the Residential Manager and that is when she "discovered" client D's abuse allegation of verbal abuse. The RC stated the RM "resigned before the investigations were completed." The RC indicated no additional staff training or retraining for immediately reporting allegations of abuse, neglect, and mistreatment was available for review. The RC indicated the RM was the person responsible for documented monthly visits of the group home to monitor program implementation and abuse, neglect, mistreatment. The RC stated "I know we did not immediately report and investigate." The RC stated "We have to take action. Our system didn't work. Staff did not report it because it was the Residential Manager (the facility staff's immediate supervisor)." The RC stated the facility's</p>			

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	<p>system "didn't protect" the clients from the potential of further abuse, neglect, and mistreatment. The RC indicated allegations of abuse, neglect, and mistreatment should have been immediately reported and were not reported.</p> <p>On 12/5/12 at 1:30pm, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS 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>The facility's 9/12 Policy for the Prevention and Resolution of Abuse, Neglect, and Mistreatment of Individuals was reviewed on 12/5/12 at 1:30pm, and 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, incidents will be reported and thoroughly investigated. (460 IAC 9) obligates Cardinal Services, Inc. to report to the</p>			

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	<p>Bureau of Developmental Disabilities Services/BDDS and Adult Protective Services (APS) any suspicion or allegation of neglect or abuse whether that suspicion or allegation is based upon fact or not. The agency may not screen such allegations...Injuries of unknown origin. Inadequate staff supports resulting in or having the potential to result in significant harm or injury to an individual...This includes inadequate supervision by staff, even when staffing levels are appropriate...Verbal Abuse Suspected, alleged, or confirmed verbal abuse of a person served. This includes oral, written, and/or gestured language that includes derogatory remarks...Neglect: Incidents involving persons served which could be construed as neglect...depriving a person served of necessary support...The reporting staff must always report all incidents immediately to an on call supervisor. That supervisor will report all incidents to the Department Coordinator for further follow up." The facility's policy and procedure did not indicate specifically who the staff should report to when the allegation concerned their immediate supervisor.</p> <p>This federal tag relates to complaint #IN00119568.</p> <p>9-3-1(a)</p>						

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement interventions and provide oversight supervision to ensure protection of clients to prevent staff abuse, neglect, and mistreatment. The facility failed to immediately report allegations of staff to client abuse, neglect, mistreatment and injuries of unknown origin to BDDS (Bureau of Developmental Disability Services), and failed to implement sufficient corrective action to prevent abuse, neglect, and mistreatment for 3 of 8 clients (clients A, B, D) living in the facility.</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected to implement their policy and procedure prohibiting abuse/neglect/mistreatment to immediately report allegations of abuse, neglect, mistreatment, and neglected to ensure oversight of the Residential Manager to ensure staff supervision and to protect clients from abuse, neglect, and mistreatment for 3 of 8 clients (clients A, B, D) who lived in the facility. The</p>	W0122	<p>W122 The facility must ensure that specific client protections requirements are met. On 12/10/2012 and again on 1/2/2013 staff were retrained on the agency's Incident/Abuse/Neglect Policy. More specifically, staff were retrained that any incident that meets BDDS reporting guidelines must be reported to the on-call supervisor immediately so an online incident report could be produced. (See attachments E-L & U-V) On 1/4/2013 the Residential Managers were trained on the updated Incident/Abuse/Neglect Policy and new reporting procedures for the on-call manager. Due to manager miscommunication client B's incident report was reported late. The new reporting procedure for on-call managers includes when the on-call manager is responsible for filing the report versus the direct manager. (W-X and E-L) The Coordinator, Residential Manager, and QDP are responsible for ensuring compliance with the BDDS incident reporting policy, agency policies and procedures, and compliance with state/federal regulations. The Residential Manager and QDP complete monthly observations in</p>	01/13/2013			

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	<p>facility neglected to immediately report client B's unknown injury.</p> <p>Please refer to W153. The facility failed to immediately report allegations of abuse and neglect and to immediately report client B's unknown injury in accordance with State Law for 3 of 5 BDDS (Bureau of Developmental Services) reports reviewed from 9/1/12 through 12/5/12 for clients B and D.</p> <p>Please refer to W157. The facility failed to take sufficient corrective action to immediately report incidents to prohibit abuse, neglect, and/or mistreatment and injuries of unknown origin for 3 of 5 BDDS (Bureau of Developmental Disability Services) reports from 9/1/12 through 12/5/12 for clients B and D.</p> <p>This federal tag relates to complaint #IN00119568.</p> <p>9-3-2(a)</p>		<p>the home to ensure compliance. The Coordinator completes quarterly checks in the group home reviewing paperwork compliance and staff observation. Coordinator, Residential Manager and QDP responsible</p>		

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 3 of 8 clients (clients A, B, D) who lived in the group home, the facility neglected to implement their policy and procedure prohibiting abuse/neglect/mistreatment to immediately report allegations of abuse, neglect, mistreatment, and neglected to ensure sufficient staff supervision and to protect clients from abuse, neglect, and mistreatment. The facility neglected to immediately report client B's unknown injury.</p> <p>Findings include:</p> <p>On 12/5/12 at 12noon, the facility BDDS (Bureau of Developmental Disability Services) reports and investigations were reviewed for the period of 9/1/12 through 12/5/12 and indicated the following allegations of abuse, neglect, and/or mistreatment:</p> <p>1. A BDDS report on 12/3/12 for an incident on 11/29/12 at 4pm, indicated on "11/29/12 [client B] went shopping with the Residential Manager (RM). They arrived at [a local large department store] at 3:30 (pm). The [second staff who</p>	W0149	<p>W149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. On 12/10/2013 and again on 1/2/2013 Direct Support Professionals were retrained on the agency's Incident/Abuse/Neglect Policy. More specifically, Direct Support Staff were retrained that any suspicion/allegation/witness of abuse, neglect, and mistreatment MUST be reported to that person's supervisor or the on-call supervisor immediately. If the allegations is against staff's direct supervisor or on-call supervisor staff are to follow the chain of command and contact the agency's Coordinator. Staff were retrained on the agency's hierarchy and whom to contact in the event a manager is the perpetrator. On 1/2/2013 the agency updated, and trained staff on, the Incident/Abuse/Neglect Policy under section 5.1, which includes "If allegation involves a person's direct supervisor, or the on-call supervisor, the staff will call that person's immediate supervisor." Furthermore, staff were retrained that the agency is committed to ensuring the safety, dignity, and protection of persons served. Additionally, on</p>	01/13/2013	

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	drove the RM and client B to the store left them at the store] at 3:45pm." The report indicated the facility second staff person returned to the store for the RM and client B at "4:10pm and parked the van near the entrance of the store." The second staff had three other clients on the van. The staff texted the RM of their arrival and waited in the van. The report indicated the second staff indicated she "did not get a response" from the RM. The "RM called the [second staff person] and stated that he could not find [client B]. At that time the second staff saw [client B] near the front door with a [store] employee." The report indicated the store employee stated to the staff person client B was leaving the store alone. The report indicated the store employee had stated to the staff that client B "was without staff...no more than 25 (twenty-five) minutes." The report indicated the RM was suspended on 11/30/12 for "an unrelated incident" and the Residential Coordinator discovered this incident during the investigation of the "unrelated incident." No retraining or evidence of corrective actions were available for review. -A BDDS report on 12/4/12 for an incident on 11/19/12 at 5pm, indicated "During an investigation for an unrelated incident the (Residential) Coordinator		1/2/2013, staff were retrained on the agency's Code of Ethics – section 3A – which states that all staff are required to meet the behavioral expectations requiring staff to work in a manner that supports the Cardinal mission, vision and beliefs. All staff are required to implement and follow an individual's plan, policies/ procedures set forth by the agency, and state/federal regulations. Between the dates of 12/3/12 – 12/8/2012 and again on 1/2/2013 staff were trained on client B's elopement plan stating that staff must be assigned to client B at all times while in the community. Client B is to be no more than an arm's length away. Between the dates of 11/13/12-11/17/2012 and again on 1/2/2013 staff were trained on client A's updated fall plan. More specifically, staff were trained that a formal assessment of the environment, in conjunction with a review of person served fall plans and/or diagnosis', will be conducted prior to a change in physical environment. The QDP and Residential Manager complete monthly observations in the group home to ensure staff are implementing person served plans, following agency policy/procedure, and state/federal guidelines. The Coordinator completes quarterly reviews in the group home, including paperwork compliance and group home observation.				

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	<p>(RC) learned that the Residential Manager had been joking around with staff and [client D] on 11/19/12. The Residential Manager told [client D] he had a Fat A--. Staff stated that [client D] appeared to be upset. The Residential Manager told [client D] I'm just joking with you Buddy. Staff told the Residential Manager that he couldn't joke with [client D]."</p> <p>2. A BDDS report on 11/13/12 for an incident on 11/12/12 at 12:14pm, indicated client A "stood up too fast and tripped on his own feet and fell onto another consumer that was sitting in a chair across from him. [Client A] stood back up and staff attempted to help him steady his gait. Staff was unable to steady [client A's] gait and he then fell into the wall next to him. Staff again tried to grab him and he fell and hit his face on the floor. He sustained a broken nose, a black right eye, and rug burn on his right knee."</p> <p>3. On 12/5/12 at 12noon, the facility BDDS (Bureau of Developmental Disability Services) reports were reviewed for the period of 9/1/12 through 12/5/12 and indicated the following late reporting for an injury of unknown origin: -A BDDS report on 11/27/12 for an incident on 11/25/12 at 8am, indicated "Staff was assisting [client B] in his</p>		(See attachments A-R) Coordinator, Residential Manager, QDP and Direct Support Professionals responsible				

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	<p>morning routine and noticed a penny size bruise in his left upper inner thigh. The origin of the bruise is unknown." The report had the witness statements attached and facility staff (FS) #1's statement indicated she discovered the bruise on "11/25/12" when she assisted him with morning routine and she "did not know where the bruise came from." No retraining for late reporting was available for review.</p> <p>Observations and interviews were completed at the group home on 12/5/12 from 3:05pm until 4:30pm. At 3:15pm, FS #17 stated clients A and B were non verbal and "none of the clients" recognized dangers or abuse. At 3:15pm, FS #17 stated client B "needed supervision in the community." FS #17 indicated she witnessed client B unsupervised at the department store when client B was left unsupervised by the RM. FS #17 stated she did not immediately report the incident because the RM was her direct supervisor. FS #17 indicated she reported the 11/29/12 incident before midnight on 11/30/12 by email after the RC had contacted her about the unrelated incident investigation with the RM earlier in the day on 11/30/12. FS #17 indicated she did not immediately report client D's verbal abuse allegation by the RM and did not</p>						

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	<p>immediately report client B's unknown injury. At 3:15pm, FS #6 stated client A "needs assistance to walk and stand up. [Client A] always had (needed staff assistance to stand/walk)." FS #6 indicated she did not immediately report client D's verbal abuse allegation by the RM and did not immediately report client B's unknown injury. At 3:45pm, FS #5 indicated she did not immediately report client D's verbal abuse allegation by the RM and did not immediately report client B's unknown injury. At 3:45pm, FS #6 stated "We had rearranged the furniture," client A got up too fast, fell into another client who was sitting down, then tripped over the rocking chair which had been moved, hit the wall, and fell to the floor on his face "hard." FS #6 stated "I knew he had to immediately go to the hospital. He was hurt." FS #6 indicated the staff redirect client A to wait for staff to assist him because his gait was unsteady.</p> <p>On 12/5/12 at 12:40pm, an interview with the QDDP (Qualified Developmental Disability Professional) was conducted. The QDDP indicated a gait belt was put into place following client A's incident. The QDDP stated client A had been unsteady and was "unsteady more" recently. The QDDP stated the staff "were to have been around" when client A went to stand up to assist him to stand upright.</p>			

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	<p>The QDDP indicated he did not have information regarding the investigations into the RM allegations of abuse and neglect.</p> <p>On 12/7/12 at 1:40pm, an interview with the RC (Residential Coordinator) was conducted. The RC stated she was in the "process" of staff retraining for abuse, neglect, and mistreatment. The RC stated an investigation was "being completed" for an unrelated incident involving the Residential Manager and that was when she "discovered" client B and D's abuse and neglect incidents. The RC stated the RM "resigned before the investigations were completed." The RC indicated no additional staff training or retraining for late reporting was available for review for allegations of abuse, neglect, and mistreatment. The RC indicated the RM was the person responsible for documented monthly visits of the group home to monitor program implementation and abuse, neglect, mistreatment. The RC stated "I know we did not immediately report." The RC stated "We have to take action. Our system didn't work. Staff did not report it because it was the Residential Manager." The RC indicated injuries of unknown origin, allegations of abuse, neglect, and mistreatment, and allegations of verbal abuse should have been immediately reported and were not</p>						

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	<p>reported. The RC stated staff were trained upon hire on how to supervise a client when going into the community and the RM "did not supervise" client B while in the community. The RC stated "it's neglect" when a client was not supervised according to their identified needs.</p> <p>Client A's record was reviewed on 12/5/12 at 12:40pm. Client A's 10/26/12 ISP (Individual Support Plan) indicated he was non verbal, required 24 hour supervision, and was to have stand by assist of staff when standing because of seizures and was unsteady on his feet when rising from sitting to a standing position.</p> <p>Client B's record was reviewed on 12/5/12 at 1:20pm. Client B's 1/5/12 ISP indicated he was non verbal and required 24 hour staff supervision. Client B's record indicated he did not recognize personal danger, abuse, or neglect. Client B did not have elopement identified as a targeted behavior in his record. Client B's record indicated on 12/4/12 an elopement risk plan was added which indicated client B was to have eyesight supervision when in the community.</p> <p>Client D's record was reviewed on 12/7/12 at 3:30pm. Client D's 2/2012 ISP indicated he was legally blind, verbal, and</p>						

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	<p>required 24 hour staff supervision. Client D's record indicated indicated he did not recognize personal danger, abuse, or neglect.</p> <p>On 12/5/12 at 1:30pm, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS 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>The facility's 9/12 Policy for the Prevention and Resolution of Abuse, Neglect, and Mistreatment of Individuals was reviewed on 12/5/12 at 1:30pm, and 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, incidents will be reported and thoroughly investigated. (460) IAC (9) obligates Cardinal Services, Inc. to report to the Bureau of Developmental Disabilities Services/BDDS and Adult Protective Services (APS) any suspicion or</p>						

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	<p>allegation of neglect or abuse whether that suspicion or allegation is based upon fact or not. The agency may not screen such allegations...Injuries of unknown origin. Inadequate staff supports resulting in or having the potential to result in significant harm or injury to an individual...This includes inadequate supervision by staff, even when staffing levels are appropriate...Verbal Abuse Suspected, alleged, or confirmed verbal abuse of a person served. This includes oral, written, and/or gestured language that includes derogatory remarks...Neglect: Incidents involving persons served which could be construed as neglect...depriving a person served of necessary support...The reporting staff must always report all incidents immediately to an on call supervisor. That supervisor will report all incidents to the Department Coordinator for further follow up."</p> <p>On 12/5/12 at 1:30pm, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. 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."</p>				

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	<p>This federal tag relates to complaint #IN00119568.</p> <p>9-3-2(a)</p>			

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W0153	<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. Based on observation, record review, and interview, for 3 of 5 BDDS (Bureau of Developmental Services) reports reviewed from 9/1/12 through 12/5/12 for clients B and D, the facility failed to immediately report allegations of abuse and neglect and to immediately report client B's unknown injury in accordance with State Law.</p> <p>Findings include:</p> <p>On 12/5/12 at 12noon, the facility BDDS reports and investigations were reviewed for the period of 9/1/12 through 12/5/12 and indicated the following allegations of abuse, neglect, and/or mistreatment:</p> <p>-A BDDS report on 12/3/12 for an incident on 11/29/12 at 4pm, indicated on "11/29/12 [client B] went shopping with the Residential Manager (RM). They arrived at [a local large department store] at 3:30 (pm). The [second staff who drove the RM and client B to the store left them at the store] at 3:45pm." The report indicated the facility second staff person</p>	W0153	W153The facility must ensure that all allegations of mistreatment, meglect 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. On 12/10/2012 and again on 1/2/2013 staff were retrained on the agency's Incident/Abuse/Neglect Policy. More specifically, staff were retrained that any incident that meets BDDS reporting guidelines must be reported to the on-call supervisor immediately so an online incident report can be produced. (See attachments E-L & U-V) On 1/4/2013 the Residential Managers were trained on the updated Incident/Abuse/Neglect Policy and new reporting procedures for the on-call manager. Due to manager miscommunication client B's incident report was reported late. The new reporting procedure for on-call managers includes when the on-call manager is responsible for filing the report versus the direct manager. (W-X and E-L) The Coordinator, Residential	01/13/2013			

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	<p>returned to the store at "4:10pm." The RM called the [second staff person] and stated that he could not find [client B]. At that time the second staff saw [client B] near the front door with a [store] employee." The report indicated the store employee stated to the staff person (that) client B was leaving the store alone. The report indicated client B "was without staff...no more than 25 (twenty-five) minutes." The report indicated the RM was suspended on 11/30/12 for "an unrelated incident" and the Residential Coordinator discovered this incident during the investigation of the "unrelated incident" and the allegation of neglect was not immediately reported.</p> <p>-A BDDS report on 12/4/12 for an incident on 11/19/12 at 5pm, indicated "During an investigation for an unrelated incident the (Residential) Coordinator (RC) learned that the Residential Manager had been joking around with staff and [client D] on 11/19/12. The Residential Manager told [client D] he had a Fat A--. Staff stated that [client D] appeared to be upset. The Residential Manager told [client D] I'm just joking with you Buddy. Staff told the Residential Manager that he couldn't joke with [client D]." The allegation of verbal abuse was not immediately reported.</p>		<p>Manager, and QDP are responsible for ensuring compliance with the BDDS incident reporting policy, agency policies and procedures, and compliance with state/federal regulations. The Residential Manager and QDP complete monthly observations in the home to ensure compliance. The Coordinator completes quarterly checks in the group home reviewing paperwork compliance and staff observation. Coordinator, Residential Manager and QDP responsible</p>				

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	<p>-A BDDS report on 11/27/12 for an incident on 11/25/12 at 8am, indicated "Staff was assisting [client B] in his morning routine and noticed a penny size bruise in his left upper inner thigh. The origin of the bruise is unknown." The report had the witness statements attached and facility staff (FS) #1's statement indicated she discovered the bruise on "11/25/12" when she assisted him with morning routine and she "did not know where the bruise came from." The unknown injury was not immediately reported.</p> <p>Observations and interviews were completed at the group home on 12/5/12 from 3:05pm until 4:30pm. At 3:15pm, FS #17 indicated she witnessed client B unsupervised at the department store when client B was left unsupervised by the RM. FS #17 stated she did not immediately report the incident because the RM was her direct supervisor. FS #17 indicated she reported the 11/29/12 incident before midnight on 11/30/12 by email after the RC had contacted her about the unrelated incident investigation with the RM earlier in the day on 11/30/12. FS #17 indicated she did not immediately report client D's verbal abuse allegation by the RM and did not immediately report client B's unknown injury. At 3:15pm, FS #6 indicated she</p>			

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	<p>did not immediately report client D's verbal abuse allegation by the RM and did not immediately report client B's unknown injury. At 3:45pm, FS #5 indicated she did not immediately report client D's verbal abuse allegation by the RM and did not immediately report client B's unknown injury.</p> <p>On 12/7/12 at 1:40pm, an interview with the RC (Residential Coordinator) was conducted. The RC stated an investigation was "being completed" for an unrelated incident of the Residential Manager and that is when she "discovered" client B and D's abuse, neglect, and mistreatment allegations. The RC stated "I know we did not immediately report." The RC indicated injuries of unknown origin, allegations of abuse, neglect, and mistreatment, and allegations of verbal abuse should have been immediately reported and were not reported.</p> <p>This federal tag relates to complaint #IN00119568.</p> <p>9-3-2(a)</p>				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G632		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/14/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 211 S BIRKEY BREMEN, IN 46506			
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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview, for 3 of 5 BDDS (Bureau of Developmental Disability Services) reports from 9/1/12 through 12/5/12 for clients B and D, the facility failed to take sufficient corrective action to immediately report incidents to prohibit abuse, neglect, and/or mistreatment and injuries of unknown origin.</p> <p>Findings include:</p> <p>On 12/5/12 at 12noon, the facility BDDS (Bureau of Developmental Disability Services) reports and investigations were reviewed for the period of 9/1/12 through 12/5/12 and indicated the following for lack of sufficient corrective action:</p> <p>-A BDDS report on 12/3/12 for an incident on 11/29/12 at 4pm, indicated on "11/29/12 [client B] went shopping with the Residential Manager (RM). They arrived at [a local large department store] at 3:30 (pm). The [facility second staff who drove the RM and client B to the store left them at the store] at 3:45pm." The report indicated the facility second staff person returned to the store for the RM and client B at "4:10pm and parked the van near the entrance of the store."</p>	W0157	<p>W157If the alleged violation is verified, appropriate corrective action must be taken.During the investigation the agency reported the incidents upon knowledge. The direct care staff did not immediately report client B's incident because her direct supervisor said he would file the report. Once the direct care staff learned her supervisor was suspended she contacted her direct supervisor's supervisor to ensure the report was filed. During the investigation, which took place between 11/30/12 - 12/6/12, staff were verbally retrained on the BDDS reporting guidelines explaining how each incident qualifies as a BDDS reportable incident. During the investigation it was learned that direct care staff didn't immediately report client D's incident because their supervisor was joking around and didn't intend to cause harm. Staff received verbal retraining on why this incident would be considered a BDDS reportable incident and that direct manager's supervisor needed contacted immediately. On December 10, 2013 an all staff meeting was held and all staff were retrained on the Incident/Abuse Neglect Policy - why the incidents are considered BDDS reportable -</p>	01/13/2013			

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	<p>The second staff had three other clients on the van, the staff texted the RM of their arrival, and waited in the van. The report indicated the second staff indicated she "did not get a response" from the RM. The RM called the [second staff person] and stated that he could not find [client B]. At that time the second staff saw [client B] near the front door with a [store] employee." The report indicated the store employee stated to the staff person (that) client B was leaving the store alone. The report indicated the store employee had stated to the staff that client B "was without staff...no more than 25 (twenty-five) minutes." The report indicated the RM was suspended on 11/30/12 for "an unrelated incident" and the Residential Coordinator discovered this incident during the investigation of the "unrelated incident." No retraining for immediately reporting was available for review.</p> <p>-A BDDS report on 12/4/12 for an incident on 11/19/12 at 5pm, indicated "During an investigation for an unrelated incident the (Residential) Coordinator (RC) learned that the Residential Manager had been joking around with staff and [client D] on 11/19/12. The Residential Manager told [client D] he had a Fat A--. Staff stated that [client D] appeared to be upset. The Residential Manager told</p>		<p>and how to report the incidents. At this meeting each staff signed a statement of commitment to follow the Incident/Abuse/Neglect Policy. (See attachments Q-R, Y - HH) On 1/2/2013 a follow up training on the Incident/Abuse/Neglect Policy occurred. This policy was updated to include what to do in the event the perpetrator was a direct supervisor or on-call supervisor. (See attachments A, and E-L)The Coordinator, QDP and Residential Manager are responsible for ensuring compliance with state/federal regulation, agency policy/procedure, and consumer plans. Additionally, the Coordinator is responsible for conducting quarterly reviews in the home for paper compliance and staff observation.Coordinator, QDP, and Residential Manager Responsible.</p>				

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	<p>[client D] I'm just joking with you Buddy. Staff told the Residential Manager that he couldn't joke with [client D]." No corrective action for immediately reporting was available for review.</p> <p>-A BDDS report on 11/27/12 for an incident on 11/25/12 at 8am, indicated "Staff was assisting [client B] in his morning routine and noticed a penny size bruise in his left upper inner thigh. The origin of the bruise is unknown." The report had the witness statements attached and facility staff (FS) #1's statement indicated she discovered the bruise on "11/25/12" when she assisted him with morning routine and she "did not know where the bruise came from." No notification was documented of immediately reporting the unknown injury. No retraining or evidence of corrective actions were available for review.</p> <p>Observations and interviews were completed at the group home on 12/5/12 from 3:05pm until 4:30pm. At 3:15pm, FS #17 stated client B "needed supervision in the community." FS #17 indicated she witnessed client B unsupervised at the department store when client B was left unsupervised by the RM. FS #17 stated she did not immediately report the incident because</p>						

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	<p>the RM was her direct supervisor. FS #17 indicated she reported the 11/29/12 incident before midnight on 11/30/12 by email after the RC had contacted her about the unrelated incident investigation with the RM earlier in the day on 11/30/12. FS #17 indicated she did not immediately report client D's verbal abuse allegation by the RM and did not immediately report client B's unknown injury. At 3:15pm, FS #6 indicated she did not immediately report client D's verbal abuse allegation by the RM and did not immediately report client B's unknown injury. At 3:45pm, FS #5 stated "none" of the clients in the group home recognized danger or if the client was being "abused." FS #5 indicated she did not immediately report client D's verbal abuse allegation by the RM and did not immediately report client B's unknown injury.</p> <p>On 12/5/12 at 12:40pm, an interview with the QDDP (Qualified Developmental Disability Professional) was conducted. The QDDP indicated he did not have information regarding investigation into the RM allegations of abuse and neglect.</p> <p>On 12/7/12 at 1:40pm, an interview with the RC (Residential Coordinator) was conducted. The RC stated she was in the "process" of staff retraining on late</p>						

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	<p>reporting for allegations of abuse, neglect, and mistreatment. The RC stated an investigation was "being completed" for an unrelated incident of the Residential Manager and that is when she "discovered" client B and D's abuse and neglect allegations. The RC indicated no additional staff training or retraining was available for review for allegations of abuse, neglect, and mistreatment. The RC indicated the RM was the person responsible for documented monthly visits of the group home to monitor program implementation and abuse, neglect, mistreatment. The RC stated "We have to take action. Our system didn't work. Staff did not report it because it was the Residential Manager." The RC indicated staff had not been retrained on reporting abuse, neglect, and/or mistreatment or reporting injuries of unknown origin.</p> <p>This federal tag relates to complaint #IN00119568.</p> <p>9-3-2(a)</p>			