

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G612	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/17/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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W 000  Bldg. 00	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: 4/7, 4/8, 4/9, 4/10, and 4/17/2015.</p> <p>Provider Number: 15G612 Facility Number: 001163 AIM Number: 100388230</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the governing body failed to provide administrative oversight over the facility to ensure client #4 received nursing services based on his identified medical and health care needs.</p> <p>Findings include:</p> <p>Please refer to W192. The governing body failed to ensure group home staff were trained and competent to provide</p>	W 104	<p>All direct supports staff, Residential Manager, QDP, and Nurse were trained on the following: The nurse will be notified prior to person being discharged so that proper after-care plans can be communicated. In the event the agency nurse is not available, another agency nurse will be contacted for assistance. (please see Med Manual page 12-13) The nurse will review and clarify all new orders from the hospital and prepare a client care plan for staff to follow. The client care</p>	05/17/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>for client #4's health and medical care at the group home after his return from his recent hospital admission for 1 of 4 sampled clients (client #4).</p> <p>Please refer to W331. The governing body failed to ensure the facility's nursing services developed protocols, ensured staff were trained, and provided supervision by a licensed health care professional specific to monitor and manage client #4's skin care, surgical site, G-tube feeding (Gastrostomy Tube, a tube for feeding into the stomach), tube residual, pain, night time protocol to prevent client #4 from pulling out his G-tube, and medical care at the group home for 1 of 4 sampled clients (client #4).</p> <p>Please refer to W344. The governing body failed to ensure the facility's nursing services employed or arranged licensed nursing services to provide oversight of client #4's health and medical care needs at the group home after his return from his recent hospital admission for 1 of 4 sampled clients (client #4).</p> <p>9-3-1(a)</p>		<p>plan will consist of detailed instructions on a treatment regimen for each medical condition, including a pain management plan and necessary documentation to support client care plan. The nurse will train all staff on the client care plan. Staff must demonstrate competency in understanding and following the plan. The nurse will monitor and assess the treatments and that all documentation is completed daily on each shift until competency has been established. The nurse will document new instructions on the nurses call log. When instructions change, the nurse will add this information in the nurse's log. (see attachment 1,2,3,4,5,6) On 4-6-15, staff completed physical assessment when client arrived home from the hospital. (see attachment 7 ) On 4-6-15, RM contacted the primary physician due to the pharmacy did not have Jevity available for clients tube feedings. The primary physician ordered Carnation instant breakfast mixed with lacto-free milk. (see attachment 8) On 4-8-15 Nurse assessed client, reviewed all discharge orders, measured blister area on hand, trained staff on orders, and left written nurses orders. (see attachment 9,10) Client was evaluated on 4-9-15 by primary physician. On 4-9--10-15, the nurse assessed the client, trained</p>				

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W 130  Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all		staff on all discharge orders and G tube placement. She tested staff for competency. (see attachment 11) Client had follow up with surgeon on 4-10-15. Nurse received new order from surgeon and trained staff on new order. The Nurse was at the home on 4-11-15. The Nurse assessed client and assisted staff. (see attachment 9,10) All staff received nurses training on 5/6/15 covering hospital admission/discharge, pain management procedure, g-tube procedure, g-tube placement and skin integrity risk plan, skin assessment tracking, bowel tracking, and leave of absence procedure. (see attached 1,2,3,4,5,6,12,13, 14,15, 30,31 ) To ensure this deficiency does not occur again, the Coordinator will review this procedure with management staff on a monthly basis during staff meetings until consistent compliance with the procedure is established. Furthermore, the Coordinator, Residential Manager, and Nurse will monitor the homes for any hospital admissions and staff will complete progress notes and send to the nurse daily with any hospital instructions or information. Coordinator, Residential Manager, and Nurse responsible.		

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	<p>clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 2 of 4 sampled clients (clients #1 and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to encourage and teach personal privacy when opportunities existed during medication administration and client #4's gastrostomy tube feeding (a feeding administered by a tube into the stomach).</p> <p>Findings include:</p> <p>On 4/7/15 from 4:05pm until 4:35pm, GHS (Group Home Staff) #1 administered clients #1 and #4's medications in the living room on the men's side of the group home. From 4:05pm until 4:35pm, clients #2, #6, and #7 walked through the living room, stood next to GHS #1 and watched GHS #1 administering the medications. At 4:25pm, GHS #1 approached client #4 who sat upright in the living room chair. GHS #1 lifted client #4's shirt, uncovered client #4's chest, client #4's gastrostomy tube (G-tube) opening, attached a syringe to the tip of the tube, and administered client #4's Carnation Instant Breakfast and Lactose Milk mixture into client #4's tube. From 4:05pm until 4:35pm, clients #2, #6, and #7 entered/exited the living</p>	W 130	<p>On 4/1/2015, QDP held an IDT where clients tube feeding was discussed. The team recommended that feeding would occur in his favorite chair and peers would be redirected during this for privacy. (see attachment 16) On 5/6/15 during a house meeting, QDP trained over Right to Privacy policy and gave staff different options of how to keep the feedings private. QDP also trained staff on ways to keep all medication passes private. (see attachment 17, 18) RM, QDP, Nurse, and Coordinator will monitor staff compliance through daily observations until consistent compliance with procedure is established. Documentation of observations will be reviewed by management/Coordinator weekly. To ensure this deficiency does not occur again, the Coordinator will review this procedure with staff on a monthly basis during house meetings until consistent compliance with the procedure is established. RM, QDP, Nurse and Coordinator responsible.</p>	05/17/2015

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	<p>room, stood next to GHS #1 who administered medications, and stood next to client #4 during his tube feeding without redirection for privacy when client #4's chest, belly, and G-tube opening were exposed.</p> <p>On 4/8/15 from 6:10am until 7:35am, GHS #2 administered client #1, #5, #6, #7's medications in the living room and kitchen of the group home and no privacy for medication administration was encouraged. From 6:10am until 7:18am, GHS #2 named clients #1, #5, #6, and #7's oral medications, their uses, and side effects while clients #1, #2, #3, #4, #5, #6, and #7 accessed the living room and kitchen and no privacy was taught or encouraged. At 7:18am, GHS #2 assembled client #4's feeding mixture of Carnation Instant Breakfast and Lactose Milk, approached client #4 who sat in the living room in a chair, exposed client #4's chest/stomach area, inserted the syringe tip into the end of client #4's stomach tube, and administered his tube feeding. During client #4's tube feeding, clients #3, #6, and #7 walked through the living room, stood next to GHS #2 who was administering the feeding, and watched client #4's tube feeding. No privacy was taught or encouraged when client #4's chest, belly, and G-tube opening were exposed.</p>			

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W 192 Bldg. 00	<p>On 4/8/15 at 8:45am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the group home had male and female clients living there. The QIDP indicated clients #1, #2, #3, #4, #5, #6, and #7 should have been redirected during formal and informal opportunities to teach and encourage personal privacy.</p> <p>9-3-2(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility failed to ensure group home staff were trained and competent to provide for client #4's health and medical care at the group home after his return from his recent hospital admission.</p> <p>Findings include:</p> <p>On 4/7/15 at 2:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for client #4:</p>	W 192	All direct supports staff, Residential Manager, QDP, and Nurse were trained on the following: The nurse will be notified prior to person being discharged so that proper after-care plans can be communicated. In the event the agency nurse is not available, another agency nurse will be contacted for assistance. (please see Med Manual page 12-13) The nurse will review and clarify all new orders from the hospital and prepare a client care plan for staff to follow. The client care plan will consist of detailed instructions on a treatment regimen for each medical	05/17/2015

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	<p>-A 3/29/15 BDDS report for an incident on 3/29/15 at 6:00am indicated staff assisted client #4 out of bed, client #4 was unable to get up by himself, client #4 was assisted to the bathroom, and "staff noticed the placement of his G-tube (gastrostomy tube) was not as it had been when he went to bed last night." The report indicated client #4 "had apparently pulled it approximately three (3) inches out of his stomach during his sleepless night." Client #4 was taken to the Emergency Room and admitted to surgically repair his G-tube.</p> <p>-A 3/18/15 BDDS report for an incident on 3/18/15 at 11:00am indicated client #4 had shortness of breath and was taken to the Emergency Room and was admitted to the hospital.</p> <p>On 4/7/15 from 3:10pm until 5:20pm, client #4 was observed at the group home. Client #4 was non verbal in that the client did not speak. Client #4 sat in the living room and had a bandage on his right arm, wrist, and hand. At 4:25pm, GHS (Group Home Staff) #1 stated the hospital staff told the group home staff that client #4 had "had some type of (allergic) reaction" to the tape used during his hospitalization and client #4 had a blister on his right thumb. GHS #1 stated "he had that when we picked him</p>		<p>condition, including a pain management plan and necessary documentation to support client care plan. The nurse will train all staff on the client care plan. Staff must demonstrate competency in understanding and following the plan. The nurse will monitor and assess the treatments and that all documentation is completed daily on each shift until competency has been established. The nurse will document new instructions on the nurses call log. When instructions change, the nurse will add this information in the nurse's log. (see attachment 1,2,3,4,5,6) On 4-6-15, staff completed physical assessment when client arrived home from the hospital. (see attachment 7 ) On 4-6-15, RM contacted the primary physician due to the pharmacy did not have Jevity available for clients tube feedings. The primary physician ordered Carnation instant breakfast mixed with lacto-free milk. (see attachment 8) On 4-8-15 Nurse assessed client, reviewed all discharge orders, measured blister area on hand, trained staff on orders, and left written nurses orders. (see attachment 9, 10) Client was evaluated on 4-9-15 by primary physician. On 4-9--10-15, the nurse assessed the client, trained staff on all discharge orders and G tube placement. She tested staff for competency. (see</p>				

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	up" from the hospital. GHS #1 indicated client #4's skin on his right arm was in this condition when client #4 returned from the hospital on 4/6/15. Client #4 had a bandage that covered his right arm, wrist, and hand which extended up client #4's arm just below his right elbow. At 4:25pm, GHS (Group Home Staff) #1 assembled client #4's feeding mixture of one (1) package of Carnation Instant Breakfast and one (1) cup Lactose Milk from the refrigerator, stirred the mixture, and placed the mixture in the microwave oven one (1) minute, and heated the mixture. At 1 minute the microwave chimed off, GHS #1 removed the heated mixture, touched the outside of the glass measuring cup with her hand, and indicated the mixture was the correct temperature. GHS #1 walked to the living room, approached client #4 who sat in the living room in a chair, exposed client #4's chest/stomach area, inserted the syringe tip into the end of client #4's stomach tube, and administered his tube feeding. GHS #1 indicated client #4 had a bandage on his stomach area where client #4 had staples to enclose the area near his G-tube. GHS #1 did not check for tube placement and did not check for residual. GHS #1 indicated the hospital nurse verbally told her and GHS #2 that the staff did not need to check for residuals before administering client #4		attachment 11) Client had follow up with surgeon on 4-10-15. Nurse received new order from surgeon and trained staff on new order. The Nurse was at the home on 4-11-15. The Nurse assessed client and assisted staff. (see attachment 9,10 ) All staff received nurses training on 5/6/15 covering hospital admission/discharge, pain management procedure, g-tube procedure, g-tube placement and skin integrity risk plan, skin assessment tracking, bowel tracking, and leave of absence procedure. (see attached 1,2,3,4,5,6,12,13,14,15, 30, 31) To ensure this deficiency does not occur again, the Coordinator will review this procedure with management staff on a monthly basis during staff meetings until consistent compliance with the procedure is established. Furthermore, the Coordinator, Residential Manager, and Nurse will monitor the homes for any hospital admissions and staff will complete progress notes and send to the nurse daily with any hospital instructions or information. Coordinator, Residential Manager, and Nurse responsible.	

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	<p>the tube feeding. When GHS #1 touched client #4's right arm, client #4 grimaced, moaned, and shifted his body in his chair.</p> <p>On 4/8/15 from 5:55am until 8:30am, client #4 was observed at the group home. At 6:30am, GHS #3 stated client #4's last tube feeding was at 8:00pm "last night" and stated "No, I have not been trained" regarding client #4's tube feeding, skin care, pain management, or medical information. GHS #3 stated she worked the "overnight" period from 12:00 midnight to 8:00am. GHS #3 stated she was "told to let him sleep through the night" and to call the on-call person if she needed to. When asked what type of medical assistance and supports client #4 required, GHS #3 stated "I don't know." At 6:55am, GHS #4 stated she had not been trained regarding client #4's tube feeding, skin care, pain management, or medical information. GHS #4 stated she worked the "overnight" period. GHS #4 indicated she would watch for client #4's facial expressions to indicate pain. GHS #4 indicated she had not been trained regarding client #4's medical care and required supports. At 6:55am, GHS #3 and GHS #4 both indicated they were the two facility staff who worked at the group home during the overnight period and GHS #1 and GHS #2 administered</p>			

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	<p>client #4's tube feedings at 7:00am until 8:00pm daily. GHS #2, GHS #3, and GHS #4 all indicated no written plans or medical information were available for review regarding client #4's new tube feeding procedure, skin assessment, skin care, surgical site, physician's orders, or pain management.</p> <p>On 4/8/15 at 7:18am, GHS #2 assembled client #4's feeding mixture of one (1) package of Carnation Instant Breakfast and one (1) cup Lactose Milk, stirred the mixture, and placed the mixture in the microwave oven twenty (20) seconds, and heated the mixture. At 20 seconds the microwave chimed off, GHS #2 removed the heated mixture, touched the mixture with her index finger, and indicated the mixture was the correct temperature. GHS #2 walked to the living room, approached client #4 who sat in the living room in a chair, exposed client #4's chest/stomach area, inserted the syringe tip into the end of client #4's stomach tube, and administered his tube feeding. GHS #2 did not check for tube placement and did not check for residual. At 7:55am, GHS #2 indicated client #4's right arm and wrist were uncovered because he had a shower today. GHS #2 indicated the skin on client #4's right arm and hand was in this condition when client #4 returned from the hospital on</p>			

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	<p>4/6/15. Client #4's skin color was bright red and had white crusty edges from just below the elbow that extended to down to client #4's right hand and thumb. GHS #2 indicated client #4's right arm, wrist, and hand open skin area was not documented in the client's record, monitored by the staff, or receiving treatment. When GHS #2 began to wrap client #4's arm, wrist, and hand with a bandage, client #4 grimaced, shifted in his chair, and moaned. No pain medication was administered or offered. At 8:00am, client #4's 4/2015 MAR (Medication Administration Record) and his medical information at the group home were reviewed. The review indicated no protocols/plans for staff to follow regarding client #4's recent surgical site, skin condition, pain, or tube feeding were available for review.</p> <p>Client #4's record was reviewed on 4/8/15 at 9:00am. Client #4's 8/19/14 ISP (Individual Support Plan) indicated client #4 was to use a "Go Talker" augmented device to communicate his wants/needs to staff. Client #4's 8/11/14 Registered Dietician's entry indicated client #4 was not receiving his nutrition needs by a G-tube. Client #4's record did not indicate any protocols or plans for client #4's recent surgical site, skin, pain, weight monitoring, bowel movement</p>			

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	<p>monitoring, or tube feeding were available for review. Client #4's "Body Checks" from 3/18/15 through 4/8/15 at 10:06am documented by the facility staff indicated client #4 had "No...evidence of a new skin issue..."</p> <p>Client #4's "3/19/15 Fax (a communication from the agency nurse to the group home staff)...Training on G-tube page 43-44 from Med (Medication) Manual. Also nurses instruction. Also if they place a G-tube Hospital should train 1 or 2 of our staff (sic)...(page 43-44) Feeding Tube...Formula should be given at room temperature, too hot or cold would make patient uncomfortable. Unused formula should be refrigerated. Refrigerated formula should be warmed to room temperature over a 30 minute period before feeding. Never heat the solution as this could increase the growth of Bacteria...Using a Syringe...3. All steps should be listed and signed for on the MAR. 4. Staff will check placement of tube as directed by physician. There are two ways to check placement. The physician will specify method for each individual. Staff will be trained by a doctor or nurse prior to checking placement. Checking for placement by aspiration of gastric contents..." signed by the agency nurse. No staff competency</p>						

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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	<p>evaluations of staff training were available for review.</p> <p>Client #4's 4/6/15 hospital Registered Dietician notes indicated "...Suggested product: Jevity 1.2...Using six feeding periods and a bolus type feeding method the following is suggested and provides: Over a 12-16 hour period. 8 ounce feeding provides 1710 calories and 79 gm (grams) of protein/day...Product should be at room temperature...monitor his weight: a significant increase in weight (a) 4-5 pound increase in weight over a 1-2 day period should be reported to the primary doctor...If stools are too loose...too hard, you may need" to increase or decrease the amount of water to flush the feeding tube. No documented evidence was available for review to indicate the agency licensed nurse was providing oversight and training of client #4's tube feeding.</p> <p>On 4/8/15 at 8:45am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4 was admitted to the hospital on 3/18/15 and had a G-tube surgically inserted into his stomach for feeding. The QIDP stated client #4 was "supposed to get Jevity" tube feeding and "our pharmacy" was unable to provide client #4's</p>			

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	<p>recommended Jevity feeding. The QIDP stated the non licensed staff at the group home called the doctor and he told them to "get a cup of Lactose Milk" from the grocery store, mix the milk with CIB (Carnation Instant Breakfast), and administer the mixture to client #4 by his G-tube. The QIDP indicated no written physician's order for the CIB and Lactose Milk mixture was available for review. The QIDP indicated the staff at the group home were non licensed in the medical field. The QIDP indicated the agency nurse was on vacation since last week and client #4 returned home from the hospital on 4/6/15. The QIDP indicated the agency nurse from another town was supposed to assess client #4 and had not assessed client #4 at this time. The QIDP indicated the agency's Registered Dietician had not been notified of client #4's recent G-tube. The QIDP indicated client #4 was non verbal, did not have a pain protocol, a skin protocol, or a protocol which included the use of CIB with Lactose Milk, surgical site from his two recent surgeries, and/or open areas on client #4's right arm, wrist, and hand available for review.</p> <p>On 4/10/15 at 11:30am, the QIDP indicated client #4's orders since returning from the hospital were not clarified with his physician by a licensed</p>						

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	<p>health care professional and client #4's medical condition was not assessed by the agency's licensed health care professional until after the surveyor requested the information for review. The QIDP provided additional information of a 4/9/15 "Medical Summary Progress Report" from client #4's physician which indicated the physician checked client #4's G-tube and staples. Client #4's 4/10/15 "Medical Summary Progress Report" indicated "Series of wounds; dressing change daily...(Medicated) cream daily to right hand then wrap hand...may have puree food one cup this week per day, increase by one cup every week until calorie oral intake met" signed by client #4's physician. Client #4's 4/8/15 "Nurses Notes, 4:15pm...Notify nurse immediately if weight gain of 5lbs (pounds) or weight loss of 5lbs. Do not heat milk, just set out ahead of time to reach room temp. (temperature). Clarify with MD (Physician) at appointment if flush (client #4's G-tube) with water throughout night and if liquid intake is adequate. Clarify if placement is to be checked before administration of any liquid into G-tube. Writer assessed wounds to R (Right) arm, measured, cleansed, dressed, per order..." signed by the agency nurse.</p>			

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W 312 Bldg. 00	<p>9-3-3(a)</p> <p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 2 sampled clients with behavior controlling medications (client #2), the facility failed to have an active treatment program for the use of client #2's sleep medication which was used to treat the client's undocumented sleep issues. The facility failed to develop a plan for client #2's medication which included a plan of reduction based on the behaviors for which the client was prescribed the medication for.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 4/9/15 at 3:15pm and on 4/10/15 at 10:15am. Client #2's 3/23/15 physician's orders indicated client #2 received Melatonin 3mg (milligrams) for night time sleep at bedtime. Client #2's 7/2014 SMP (Self Management Plan) did not indicate the use of Melatonin medication for night time sleep. Client #2's SMP indicated targeted behaviors of SIB (Self</p>	W 312	QDP developed a quarterly review of the clients sleep patterns and medication that will be reviewed by the primary doctor. QDP trained all staff on sleep chart and implementation. The nurse trained staff on communication with the physician regarding sleep pattern. (see attachment 19,20,21,22) Doctor will review quarterly and make adjustments when needed. (see attachment 34) QDP and Nurse responsible.	05/17/2015

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W 318 Bldg. 00	<p>Injurious Behaviors) and Physical Aggression. Client #2's Melatonin was not included into the SMP and/or ISP (Individual Support Plan). Client #2's record did not include a plan of reduction based on the behaviors for which the medication was prescribed.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) on 4/10/15 11:40am was conducted. The QIDP indicated client #2 had a diagnosis of Bipolar Disorder, CP (Cerebral Palsy), Scoliosis, and Spasticity. The QIDP indicated the Melatonin was prescribed to ensure client #2 had a restful sleep during the night because of her CP. The QIDP indicated no active treatment program was available for review which included client #2's Melatonin medication.</p> <p>9-3-5(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview, and record review for 1 of 4 sampled clients (client #4), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure nursing services</p>	W 318	All direct supports staff, Residential Manager, QDP, and Nurse were trained on the following: The nurse will be notified prior to person being discharged so that proper after-care plans can be communicated. In the event the	05/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G612		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  04/17/2015	
NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947			
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	<p>met client #4's medical needs in regard to completing assessments, development of nursing care plans, providing staff training, and monitoring of client #4's skin integrity, dressing care, pain management, and client #4's health status.</p> <p>Findings include:</p> <p>Please refer to W331. The facility's nursing services failed to develop protocols, ensure staff were trained, and provide supervision by a licensed health care professional specific to monitor and manage client #4's skin care, surgical site, G-tube feeding (Gastrostomy Tube, a tube for feeding into the stomach), tube residual, pain, night time protocol to prevent client #4 from pulling out his G-tube, and medical care at the group home for 1 of 4 sampled clients (client #4).</p> <p>Please refer to W344. The facility's nursing services failed to employ or arrange licensed nursing services to provide oversight of client #4's health and medical care needs at the group home after his return from his recent hospital admission for 1 of 4 sampled clients (client #4).</p> <p>9-3-6(a)</p>		<p>agency nurse is not available, another agency nurse will be contacted for assistance. (please see Med Manual page 12-13) The nurse will review and clarify all new orders from the hospital and prepare a client care plan for staff to follow. The client care plan will consist of detailed instructions on a treatment regimen for each medical condition, including a pain management plan and necessary documentation to support client care plan. The nurse will train all staff on the client care plan. Staff must demonstrate competency in understanding and following the plan. The nurse will monitor and assess the treatments and that all documentation is completed daily on each shift until competency has been established. The nurse will document new instructions on the nurses call log. When instructions change, the nurse will add this information in the nurse's log. (see attachment 1,2,3,4,5,6, 33) On 4-6-15, staff completed physical assessment when client arrived home from the hospital. (see attachment 7 ) On 4-6-15, RM contacted the primary physician due to the pharmacy did not have Jevity available for clients tube feedings. The primary physician ordered Carnation instant breakfast mixed with lacto-free milk. (see attachment 8) On 4-8-15 Nurse assessed</p>				

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			<p>client, reviewed all discharge orders, measured blister area on hand, trained staff on orders, and left written nurses orders. (see attachment 9,10) Client was evaluated on 4-9-15 by primary physician. On 4-9--10-15, the nurse assessed the client, trained staff on all discharge orders and G tube placement. She tested staff for competency. (attachment 11) Client had follow up with surgeon on 4-10-15. Nurse received new order from surgeon and trained staff on new order. The Nurse was at the home on 4-11-15. The Nurse assessed client and assisted staff. (see attachment 9,10) All staff received nurses training on 5/6/15 covering hospital admission/discharge, pain management procedure, g-tube procedure, g-tube placement and skin integrity risk plan, skin assessment tracking, bowel tracking, and leave of absence procedure. (see attached 1,2,3,4,5,6,12,13,14,15,16, 30 31 ) To ensure this deficiency does not occur again, the Coordinator will review this procedure with management staff on a monthly basis during staff meetings until consistent compliance with the procedure is established. Furthermore, the Coordinator, Residential Manager, and Nurse will monitor the homes for any hospital admissions and staff will complete progress notes and</p>	

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W 331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility's nursing services failed to develop protocols, ensure staff were trained, and provide supervision by a licensed health care professional specific to monitor and to manage client #4's skin care, surgical site, G-tube feeding (Gastrostomy Tube, a tube for feeding into the stomach), tube residual, pain, night time protocol to prevent client #4 from pulling out his G-tube, and medical care at the group home.</p> <p>Findings include:</p> <p>On 4/7/15 at 2:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for client #4: -A 3/29/15 BDDS report for an incident on 3/29/15 at 6:00am indicated staff assisted client #4 out of bed, client #4 was unable to get up by himself, client #4 was assisted to the bathroom, and "staff noticed the placement of his G-tube was</p>	W 331	<p>send to the nurse daily with any hospital instructions or information. Coordinator, Residential Manager, and Nurse responsible.</p> <p>All direct supports staff, Residential Manager, QDP, and Nurse were trained on the following: The nurse will be notified prior to person being discharged so that proper after-care plans can be communicated. In the event the agency nurse is not available, another agency nurse will be contacted for assistance. (please see Med Manual page 12-13) The nurse will review and clarify all new orders from the hospital and prepare a client care plan for staff to follow. The client care plan will consist of detailed instructions on a treatment regimen for each medical condition, including a pain management plan and necessary documentation to support client care plan. The nurse will train all staff on the client care plan. Staff must demonstrate competency in understanding and following the plan. The nurse will monitor and assess the treatments and that all documentation is completed daily on each shift until competency has been established. The</p>	05/17/2015

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	<p>not as it had been when he went to bed last night." The report indicated client #4 "had apparently pulled it approximately three (3) inches out of his stomach during his sleepless night." Client #4 was taken to the Emergency Room and admitted to surgically repair his G-tube.</p> <p>-A 3/18/15 BDDS report for an incident on 3/18/15 at 11:00am indicated client #4 had shortness of breath and was taken to the Emergency Room and was admitted to the hospital.</p> <p>On 4/7/15 from 3:10pm until 5:20pm, client #4 was observed at the group home. Client #4 was non verbal in that the client did not speak. Client #4 sat in the living room and had a bandage on his right arm, wrist, and hand. At 4:25pm, GHS (Group Home Staff) #1 stated the hospital staff told the group home staff that client #4 had "had some type of (allergic) reaction" to the tape used during his hospitalization and client #4 had a blister on his right thumb. GHS #1 stated "he had that when we picked him up" from the hospital. GHS #1 indicated client #4's skin on his right arm was in this condition when client #4 returned from the hospital on 4/6/15. Client #4 had a bandage that covered his right arm, wrist, and hand which extended up client #4's arm just below his right elbow. At</p>		<p>nurse will document new instructions on the nurses call log. When instructions change, the nurse will add this information in the nurse's log. (see attachment 1,2,3,4,5,6) On 4-6-15, staff completed physical assessment when client arrived home from the hospital. (see attachment 7 ) On 4-6-15, RM contacted the primary physician due to the pharmacy did not have Jevity available for clients tube feedings. The primary physician ordered Carnation instant breakfast mixed with lacto-free milk. (see attachment 8) Staff were tracking bowel movements since release from hospital. (see attachment 14 ) On 4-8-15 Nurse assessed client, reviewed all discharge orders, measured blister area on hand, trained staff on orders, and left written nurses orders. (see attachment 9,10) Client was evaluated on 4-9-15 by primary physician. On 4-9--10-15, the nurse assessed the client, trained staff on all discharge orders and G tube placement. She tested staff for competency. (attachment 11) Client had follow up with surgeon on 4-10-15. Nurse received new order from surgeon and trained staff on new order. The Nurse was at the home on 4-11-15. The Nurse assessed client and assisted staff. (see attachment 9,10 ) QDP adjusted clients goal for the go talk on 4/10/15. The goal was for client</p>		

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	<p>4:25pm, GHS (Group Home Staff) #1 assembled client #4's feeding mixture of one (1) package of Carnation Instant Breakfast and one (1) cup Lactose Milk from the refrigerator, stirred the mixture, and placed the mixture in the microwave oven one (1) minute, and heated the mixture. At 1 minute the microwave chimed off, GHS #1 removed the heated mixture, touched the outside of the glass measuring cup with her hand, and indicated the mixture was the correct temperature. GHS #1 walked to the living room, approached client #4 who sat in the living room in a chair, exposed client #4's chest/stomach area, inserted the syringe tip into the end of client #4's stomach tube, and administered his tube feeding. GHS #1 indicated client #4 had a bandage on his stomach area where client #4 had staples to enclose the area near his G-tube. GHS #1 did not check for tube placement and did not check for residual. GHS #1 indicated the hospital nurse verbally told her and GHS #2 that the staff did not need to check for residuals before administering client #4 the tube feeding. When GHS #1 touched client #4's right arm, client #4 grimaced, moaned, and shifted his body in his chair.</p> <p>On 4/8/15 from 5:55am until 8:30am, client #4 was observed at the group home. At 6:30am, GHS #3 stated client</p>		<p>to make a choice of drinks but since he no longer takes fluids by mouth, it was adjusted to make choices of activities. (see attachment 23,24) All staff were trained on new goal. All staff received nurses training on 5/6/15 covering hospital admission/discharge, pain management procedure, g-tube procedure, g-tube placement and skin integrity risk plan, skin assessment tracking, bowel tracking, and leave of absence procedure. (see attached 1,2,3,4,5,6,12,13,14,15, 30 31) To ensure this deficiency does not occur again, the Coordinator will review this procedure with management staff on a monthly basis during staff meetings until consistent compliance with the procedure is established. Furthermore, the Coordinator, Residential Manager, and Nurse will monitor the homes for any hospital admissions and staff will complete progress notes and send to the nurse daily with any hospital instructions or information. Coordinator, Residential Manager, and Nurse responsible.</p>	

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	#4's last tube feeding was at 8:00pm "last night" and stated "No, I have not been trained" regarding client #4's tube feeding, skin care, pain management, or medical information. GHS #3 stated she worked the "overnight" period from 12:00 midnight to 8:00am. GHS #3 stated she was "told to let him sleep through the night" and to call the on-call person if she needed to. When asked what type of medical assistance and supports client #4 required, GHS #3 stated "I don't know." At 6:55am, GHS #4 stated she had not been trained regarding client #4's tube feeding, skin care, pain management, or medical information. GHS #4 stated she worked the "overnight" period. GHS #4 indicated she would watch for client #4's facial expressions to indicate pain. GHS #4 indicated she had not been trained regarding client #4's medical care and required supports. At 6:55am, GHS #3 and GHS #4 both indicated they were the two facility staff who worked at the group home during the overnight period and GHS #1 and GHS #2 administered client #4's tube feedings at 7:00am until 8:00pm daily. GHS #2, GHS #3, and GHS #4 all indicated no written plans or medical information were available for review regarding client #4's new tube feeding procedure, skin assessment, skin care, surgical site, physician's orders, or			

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	<p>pain assessment/plan.</p> <p>On 4/8/15 at 7:18am, GHS #2 assembled client #4's feeding mixture of one (1) package of Carnation Instant Breakfast and one (1) cup Lactose Milk, stirred the mixture, and placed the mixture in the microwave oven twenty (20) seconds, and heated the mixture. At 20 seconds the microwave chimed off, GHS #2 removed the heated mixture, touched the mixture with her index finger, and indicated the mixture was the correct temperature. GHS #2 walked to the living room, approached client #4 who sat in the living room in a chair, exposed client #4's chest/stomach area, inserted the syringe tip into the end of client #4's stomach tube, and administered his tube feeding. GHS #2 did not check for tube placement and did not check for residual. At 7:55am, GHS #2 indicated client #4's right arm and wrist were uncovered because he had a shower today. GHS #2 indicated the skin on client #4's right arm and hand was in this condition when client #4 returned from the hospital on 4/6/15. Client #4's skin color was bright red and had white crusty edges from just below the elbow that extended to down to client #4's right hand and thumb. GHS #2 indicated client #4's right arm, wrist, and hand open skin area was not documented in the client's record,</p>			

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	<p>monitored by the facility staff, or receiving treatment. When GHS #2 began to wrap client #4's arm, wrist, and hand with a bandage, client #4 grimaced, shifted in his chair, and moaned. No pain medication was administered or offered. At 8:00am, client #4's 4/2015 MAR (Medication Administration Record) and his medical information at the group home were reviewed. The review indicated no protocols/plans for client #4's recent surgical site, skin, pain, or tube feeding were available for review.</p> <p>Client #4's record was reviewed on 4/8/15 at 9:00am. Client #4's 8/19/14 ISP (Individual Support Plan) indicated client #4 was to use a "Go Talker" augmented device to communicate his wants/needs to staff. Client #4's 8/11/14 Registered Dietician's entry indicated client #4 was not receiving his nutrition needs by a G-tube. Client #4's record did not indicate protocols or plans for client #4's recent surgical site, skin, pain, medical care, weight monitoring, bowel movement monitoring, or tube feeding were available for review. Client #4's "Body Checks" from 3/18/15 through 4/8/15 at 10:06am indicated client #4 had "No...evidence of a new skin issue..."</p> <p>Client #4's "3/19/15 Fax (a communication sent to the group home</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G612	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/17/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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	<p>from the agency nurse)...Training on G-tube page 43-44 from Med (Medication) Manual. Also nurses instruction. Also if they place a G-tube Hospital should train 1 or 2 of our staff (sic)...(page 43-44) Feeding Tube...Formula should be given at room temperature, too hot or cold would make patient uncomfortable. Unused formula should be refrigerated. Refrigerated formula should be warmed to room temperature over a 30 minute period before feeding. Never heat the solution as this could increase the growth of Bacteria...Using a Syringe...3. All steps should be listed and signed for on the MAR. 4. Staff will check placement of tube as directed by physician. There are two ways to check placement. The physician will specify method for each individual. Staff will be trained by a doctor or nurse prior to checking placement. Checking for placement by aspiration of gastric contents..." signed by the agency nurse. No staff competency evaluations of staff training were available for review.</p> <p>Client #4's 4/6/15 hospital Registered Dietician notes indicated "...Suggested product: Jevity 1.2...Using six feeding periods and a bolus type feeding method the following is suggested and provides: Over a 12-16 hour period. 8 ounce</p>			

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	<p>feeding provides 1710 calories and 79 gm (grams) of protein/day...Product should be at room temperature...monitor his weight: a significant increase in weight (a) 4-5 pound increase in weight over a 1-2 day period should be reported to the primary doctor...If stools are too loose...too hard, you may need" to increase or decrease the amount of water to flush the feeding tube. No documented evidence was available for review to indicate the agency licensed nurse was providing oversight and training of client #4's tube feeding.</p> <p>On 4/8/15 at 8:45am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4 was admitted to the hospital on 3/18/15 and had a G-tube surgically inserted into his stomach for feeding. The QIDP stated client #4 was "supposed to get Jevity" tube feeding and "our pharmacy" was unable to provide client #4's recommended Jevity feeding. The QIDP stated the non licensed staff at the group home called the doctor and he told them to "get a cup of Lactose Milk" from the grocery store, mix the milk with CIB (Carnation Instant Breakfast), and administer the mixture to client #4 by his G-tube. The QIDP indicated no written physician's order for the CIB and Lactose</p>			

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	<p>Milk mixture was available for review. The QIDP indicated the staff at the group home were non licensed in the medical field. The QIDP indicated the agency nurse was on vacation since last week and client #4 returned home from the hospital on 4/6/15. The QIDP indicated the agency nurse from another town was supposed to assess client #4 and had not assessed client #4 at this time. The QIDP indicated the agency's Registered Dietician had not been notified of client #4's recent G-tube. The QIDP indicated client #4 was non verbal, did not have a pain protocol, a skin protocol, or a protocol which included the use of CIB with Lactose Milk, surgical site from his two recent surgeries, and/or open areas on client #4's right arm, wrist, and hand available for review.</p> <p>On 4/10/15 at 11:30am, the QIDP indicated client #4's orders since returning from the hospital were not clarified with his physician by a licensed health care professional and client #4's medical condition was not assessed by the agency's licensed health care professional until after the surveyor requested the information for review. The QIDP provided additional information of a 4/9/15 "Medical Summary Progress Report" from client #4's physician which indicated the</p>				

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W 344 Bldg. 00	<p>physician checked client #4's G-tube and staples. Client #4's 4/10/15 "Medical Summary Progress Report" indicated "Series of wounds; dressing change daily...(Medicated) cream daily to right hand then wrap hand...may have puree food one cup this week per day, increase by one cup every week until calorie oral intake met" signed by client #4's physician. Client #4's 4/8/15 "Nurses Notes, 4:15pm...Notify nurse immediately if weight gain of 5lbs (pounds) or weight loss of 5lbs. Do not heat milk, just set out ahead of time to reach room temp. (temperature). Clarify with MD (Physician) at appointment if flush (client #4's G-tube) with water throughout night and if liquid intake is adequate. Clarify if placement is to be checked before administration of any liquid into G-tube. Writer assessed wounds to R (Right) arm, measured, cleansed, dressed, per order..." signed by the agency nurse.</p> <p>9-3-6(a)</p> <p>483.460(d)(2) NURSING STAFF The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans. Based on observation, record review, and</p>	W 344	All direct supports staff, Residential Manager, QDP, and	05/17/2015

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	<p>interview, for 1 of 4 sampled clients (client #4), the facility's nursing services failed to employ or arrange licensed nursing services to provide oversight of client #4's health and medical care needs at the group home after his return from his recent hospital admission.</p> <p>Findings include:</p> <p>On 4/7/15 at 2:20pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for client #4: -A 3/29/15 BDDS report for an incident on 3/29/15 at 6:00am indicated staff assisted client #4 out of bed, client #4 was unable to get up by himself, client #4 was assisted to the bathroom, and "staff noticed the placement of his G-tube was not as it had been when he went to bed last night." The report indicated client #4 "had apparently pulled it approximately three (3) inches out of his stomach during his sleepless night." Client #4 was taken to the Emergency Room and admitted to surgically repair his G-tube.</p> <p>-A 3/18/15 BDDS report for an incident on 3/18/15 at 11:00am indicated client #4 had shortness of breath and was taken to the Emergency Room and was admitted to the hospital.</p>		<p>Nurse were trained on the following: The nurse will be notified prior to person being discharged so that proper after-care plans can be communicated. In the event the agency nurse is not available, another agency nurse will be contacted for assistance. (please see Med Manual page 12-13) The nurse will review and clarify all new orders from the hospital and prepare a client care plan for staff to follow. The client care plan will consist of detailed instructions on a treatment regimen for each medical condition, including a pain management plan and necessary documentation to support client care plan. The nurse will train all staff on the client care plan. Staff must demonstrate competency in understanding and following the plan. The nurse will monitor and assess the treatments and that all documentation is completed daily on each shift until competency has been established. The nurse will document new instructions on the nurses call log. When instructions change, the nurse will add this information in the nurse's log. (see attachment 1,2,3,4,5,6) On 4-6-15, staff completed physical assessment when client arrived home from the hospital. (see attachment 7 ) On 4-6-15, RM contacted the primary physician due to the pharmacy did not have</p>				

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	<p>On 4/7/15 from 3:10pm until 5:20pm, client #4 was observed at the group home. Client #4 was non verbal as the client did not speak. Client #4 sat in the living room and had a bandage on his right arm, wrist, and hand. At 4:25pm, GHS (Group Home Staff) #1 stated the hospital staff told the group home staff that client #4 had "had some type of (allergic) reaction" to the tape used during his hospitalization and client #4 had a blister on his right thumb. GHS #1 stated "he had that when we picked him up" from the hospital. GHS #1 indicated client #4's right arm skin was in this condition when client #4 returned from the hospital on 4/6/15. Client #4 had a bandage that covered his right arm, wrist, and hand which extended up client #4's arm just below his right elbow. At 4:25pm, GHS (Group Home Staff) #1 assembled client #4's feeding mixture of one (1) package of Carnation Instant Breakfast and one (1) cup Lactose Milk from the refrigerator, stirred the mixture, and placed the mixture in the microwave oven one (1) minute, and heated the mixture. At 1 minute the microwave chimed off, GHS #1 removed the heated mixture, touched the outside of the glass measuring cup with her hand, and indicated the mixture was the correct temperature. GHS #1 walked to the living room, approached client #4 who</p>		<p>Jevity available for clients tube feedings. The primary physician ordered Carnation instant breakfast mixed with lacto-free milk. (see attachment 8) On 4-8-15 Nurse assessed client, reviewed all discharge orders, measured blister area on hand, trained staff on orders, and left written nurses orders. (see attachment 9,10) Client was evaluated on 4-9-15 by primary physician. On 4-9--10-15, the nurse assessed the client, trained staff on all discharge orders and G tube placement. She tested staff for competency. (see attachment 11) Client had follow up with surgeon on 4-10-15. Nurse received new order from surgeon and trained staff on new order. The Nurse was at the home on 4-11-15. The Nurse assessed client and assisted staff. (see attachment 9,10) All staff received nurses training on 5/6/15 covering hospital admission/discharge, pain management procedure, g-tube procedure, g-tube placement and skin integrity risk plan, skin assessment tracking, bowel tracking, and leave of absence procedure. (see attached 1,2,3,4,5,6,12,13,14,15, 30,31) To ensure this deficiency does not occur again, the Coordinator will review this procedure with management staff on a monthly basis during staff meetings until consistent compliance with the procedure is established.</p>				

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	<p>sat in the living room in a chair, exposed client #4's chest/stomach area, inserted the syringe tip into the end of client #4's stomach tube, and administered his tube feeding. GHS #1 indicated client #4 had a bandage on his stomach area where client #4 had staples to enclose the area near his G-tube. GHS #1 did not check for tube placement and did not check for residual. GHS #1 indicated the hospital nurse verbally told her and GHS #2 that the staff did not need to check for residuals before administering client #4 the tube feeding. When GHS #1 touched client #4's right arm, client #4 grimaced, moaned, and shifted his body in his chair.</p> <p>On 4/8/15 from 5:55am until 8:30am, client #4 was observed at the group home. At 6:30am, GHS #3 stated client #4's last tube feeding was at 8:00pm "last night" and stated "No, I have not been trained" regarding client #4's tube feeding, skin care, pain management, or medical information. GHS #3 stated she worked the "overnight" period from 12:00 midnight to 8:00am. GHS #3 stated she was "told to let him sleep through the night" and to call the on-call person if she needed to. When asked what type of medical assistance and supports client #4 required, GHS #3 stated "I don't know." At 6:55am, GHS #4 stated she had not been trained</p>		<p>Furthermore, the Coordinator, Residential Manager, and Nurse will monitor the homes for any hospital admissions and staff will complete progress notes and send to the nurse daily with any hospital instructions or information. Coordinator, Residential Manager, and Nurse responsible.</p>	

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	<p>regarding client #4's tube feeding, skin care, pain management, or medical information. GHS #4 stated she worked the "overnight" period. GHS #4 indicated she would watch for client #4's facial expressions to indicate pain. GHS #4 indicated she had not been trained regarding client #4's medical care and required supports. At 6:55am, GHS #3 and GHS #4 both indicated they were the two facility staff who worked at the group home during the overnight period and GHS #1 and GHS #2 administered client #4's tube feedings at 7:00am until 8:00pm daily. GHS #2, GHS #3, and GHS #4 all indicated no written plans or medical information were available for review regarding client #4's new tube feeding procedure, skin assessment, skin care, surgical site, physician's orders, or pain assessment/plan.</p> <p>On 4/8/15 at 7:18am, GHS #2 assembled client #4's feeding mixture of one (1) package of Carnation Instant Breakfast and one (1) cup Lactose Milk, stirred the mixture, and placed the mixture in the microwave oven twenty (20) seconds, and heated the mixture. At 20 seconds the microwave chimed off, GHS #2 removed the heated mixture, touched the mixture with her index finger, and indicated the mixture was the correct temperature. GHS #2 walked to the</p>			

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	<p>living room, approached client #4 who sat in the living room in a chair, exposed client #4's chest/stomach area, inserted the syringe tip into the end of client #4's stomach tube, and administered his tube feeding. GHS #2 did not check for tube placement and did not check for residual. At 7:55am, GHS #2 indicated client #4's right arm and wrist were uncovered because he had a shower today. GHS #2 indicated the skin on client #4's right arm and hand was in this condition when client #4 returned from the hospital on 4/6/15. Client #4's skin color was bright red and had white crusty edges from just below the elbow that extended to down to client #4's right hand and thumb. GHS #2 indicated client #4's right arm, wrist, and hand open skin area was not documented in the client's record, monitored by the facility staff, or receiving treatment. When GHS #2 began to wrap client #4's arm, wrist, and hand with a bandage, client #4 grimaced, shifted in his chair, and moaned. No pain medication was administered or offered. At 8:00am, client #4's 4/2015 MAR (Medication Administration Record) and his medical information at the group home were reviewed. The review indicated no protocols/plans for client #4's recent surgical site, skin, pain, or tube feeding were available for review.</p>			

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	<p>Client #4's record was reviewed on 4/8/15 at 9:00am. Client #4's 8/19/14 ISP (Individual Support Plan) indicated client #4 was to use a "Go Talker" augmented device to communicate his wants/needs to staff. Client #4's 8/11/14 Registered Dietician's entry indicated client #4 was not receiving his nutrition needs by a G-tube. Client #4's record did not indicate protocols or plans for client #4's recent surgical site, skin, pain, medical care, weight monitoring, bowel movement monitoring, or tube feeding were available for review. Client #4's "Body Checks" from 3/18/15 through 4/8/15 at 10:06am indicated client #4 had "No...evidence of a new skin issue..."</p> <p>Client #4's "3/19/15 Fax (a communication sent to the group home from the agency nurse)...Training on G-tube page 43-44 from Med (Medication) Manual. Also nurses instruction. Also if they place a G-tube Hospital should train 1 or 2 of our staff (sic)...(page 43-44) Feeding Tube...Formula should be given at room temperature, too hot or cold would make patient uncomfortable. Unused formula should be refrigerated. Refrigerated formula should be warmed to room temperature over a 30 minute period before feeding. Never heat the solution as this could increase the growth of</p>			

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	<p>Bacteria...Using a Syringe...3. All steps should be listed and signed for on the MAR. 4. Staff will check placement of tube as directed by physician. There are two ways to check placement. The physician will specify method for each individual. Staff will be trained by a doctor or nurse prior to checking placement. Checking for placement by aspiration of gastric contents..." signed by the agency nurse. No staff competency evaluations of staff training were available for review.</p> <p>Client #4's 4/6/15 hospital Registered Dietician notes indicated "...Suggested product: Jevity 1.2...Using six feeding periods and a bolus type feeding method the following is suggested and provides: Over a 12-16 hour period. 8 ounce feeding provides 1710 calories and 79 gm (grams) of protein/day...Product should be at room temperature...monitor his weight: a significant increase in weight (a) 4-5 pound increase in weight over a 1-2 day period should be reported to the primary doctor...If stools are too loose...too hard, you may need" to increase or decrease the amount of water to flush the feeding tube. No documented evidence was available for review to indicate the agency licensed nurse was providing oversight and training of client #4's tube feeding.</p>			

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	<p>On 4/8/15 at 8:45am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4 was admitted to the hospital on 3/18/15 and had a G-tube surgically inserted into his stomach for feeding. The QIDP stated client #4 was "supposed to get Jevity" tube feeding and "our pharmacy" was unable to provide client #4's recommended Jevity feeding. The QIDP stated the non licensed staff at the group home called the doctor and he told them to "get a cup of Lactose Milk" from the grocery store, mix the milk with CIB (Carnation Instant Breakfast), and administer the mixture to client #4 by his G-tube. The QIDP indicated no written physician's order for the CIB and Lactose Milk mixture was available for review. The QIDP indicated the staff at the group home were non licensed in the medical field. The QIDP indicated the agency nurse was on vacation since last week and client #4 returned home from the hospital on 4/6/15. The QIDP indicated the agency nurse from another town was supposed to assess client #4 and had not assessed client #4 at this time. The QIDP indicated the agency's Registered Dietician had not been notified of client #4's recent G-tube. The QIDP indicated client #4 was non verbal, did not have a</p>			

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	<p>pain protocol, a skin protocol, or a protocol which included the use of CIB with Lactose Milk, surgical site from his two recent surgeries, and/or open areas on client #4's right arm, wrist, and hand available for review.</p> <p>On 4/10/15 at 11:30am, the QIDP indicated client #4's orders since returning from the hospital were not clarified with his physician by a licensed health care professional and client #4's medical condition was not assessed by the agency's licensed health care professional until after the surveyor requested the information for review. The QIDP provided additional information of a 4/9/15 "Medical Summary Progress Report" from client #4's physician which indicated the physician checked client #4's G-tube and staples. Client #4's 4/10/15 "Medical Summary Progress Report" indicated "Series of wounds; dressing change daily...(Medicated) cream daily to right hand then wrap hand...may have puree food one cup this week per day, increase by one cup every week until calorie oral intake met" signed by client #4's physician. Client #4's 4/8/15 "Nurses Notes, 4:15pm...Notify nurse immediately if weight gain of 5lbs (pounds) or weight loss of 5lbs. Do not heat milk, just set out ahead of time to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G612	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/17/2015
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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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W 436 Bldg. 00	<p>reach room temp. (temperature). Clarify with MD (Physician) at appointment if flush (client #4's G-tube) with water throughout night and if liquid intake is adequate. Clarify if placement is to be checked before administration of any liquid into G-tube. Writer assessed wounds to R (Right) arm, measured, cleansed, dressed, per order..." signed by the agency nurse.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #3 and #4) with adaptive equipment, the facility failed to encourage the use of client #4's augmented communication device to communicate and to have the device available and failed to ensure client #3's wheelchair was in good repair.</p> <p>Findings include:</p> <p>1. On 4/7/15 from 3:10pm until 5:20pm,</p>	W 436	QDP adjusted clients goal to better utilize clients augmented communication device. QDP trained over non verbal communication and ways to better utilize gestures with clients. QDP trained all staff over the new goal and implementation of the device. QDP trained staff on cleaning of adaptive equipment and the check list and how to properly report any broken or worn parts. (see attachment 23,24,25,26,27) Client had appointment on 5/6/15 with primary doctor and received an	05/17/2015

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	<p>client #4 was observed at the group home and was non verbal in that the client did not speak. From 3:10pm until 5:20pm, client #4 sat in the living room and had a bandage on his right arm, wrist, and hand. GHS #1 stated the hospital staff told the group home staff that client #4 had "had some type of (allergic) reaction" to the tape used during his hospitalization and client #4 had a blister on his right thumb. Client #4 had a bandage that covered his right arm, wrist, and hand which extended up client #4's arm just below his right elbow. At 4:25pm, GHS (Group Home Staff) #1 assembled client #4's feeding mixture, stirred the mixture, and administered client #4's tube feeding. GHS #1 indicated client #4 had a bandage on his stomach area where client #4 had surgical staples to enclose the area near his G-tube. When GHS #1 touched client #4's right arm, client #4 grimaced, moaned, and shifted his body in his chair. During the observation period client #4 did not use a communication book and/or an augmented communication device to communicate. During the observation period staff communicated verbal requests with limited gestures to client #4 and client #4 was not prompted to communicate with the group home staff.</p> <p>On 4/8/15 from 5:55am until 8:30am, client #4 was observed at the group</p>		<p>order to be evaluated for wheel chair. (see attachment 28) Client has an OT appointment scheduled for 5/12/15 to be evaluated for a new wheelchair. RM, QDP, Nurse, and Coordinator will monitor staff compliance though weekly observations until consistent compliance with procedure is established. Documentation of observations will be reviewed by management/Coordinator weekly. To ensure this deficiency does not occur again, the Coordinator will review this procedure with staff on a monthly basis during house meetings until consistent compliance with the procedure is established. RM, QDP, and Nurse responsible.</p>	

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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	<p>home. At 6:55am, GHS #4 indicated she would watch for client #4's facial expressions to indicate pain.</p> <p>On 4/8/15 at 7:18am, GHS #2 assembled client #4's feeding mixture and stirred the mixture. GHS #2 walked to the living room, approached client #4 who sat in the living room in a chair, and administered his tube feeding. At 7:55am, GHS #2 indicated client #4's right arm and wrist were uncovered because he had a shower today. Client #4's skin color was bright red and had white crusty edges from just below the elbow that extended to down to client #4's right hand and thumb. When GHS #2 began to wrap client #4's arm, wrist, and hand with a bandage, client #4 grimaced, shifted in his chair, and moaned. During the observation period client #4 did not use a communication book and/or an augmented communication device to communicate. During the observation period staff communicated verbal requests with limited gestures to client #4 and client #4 was not prompted to communicate with the group home staff.</p> <p>Client #4's record was reviewed on 4/8/15 at 9:00am. Client #4's 8/19/14 ISP (Individual Support Plan) indicated a goal/objective to use his Go-Talk communication device to communicate</p>			

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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	<p>his wants/needs to the facility staff. Client #4's ISP indicated he was non verbal and used his augmented Go Talk communication device to communicate. Client #4's 4/10/2010 Speech Therapy (ST) assessment included recommendations for client #4 to use an output (augmented) device and the facility staff "should add gestures to requests" when communicating with client #4.</p> <p>On 4/8/15 at 8:45am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Community Services Coordinator (CSC) was conducted. The CSC and the QIDP indicated client #4 had a Go Talk augmented communication device he was to use when staff or people wanted to communicate. The QIDP indicated client #4's communication goal was in place to teach client #4 to use the Go Talk augmented device and should have been implemented during formal and informal opportunities. The QIDP indicated she did not know the current location of client #4's communication device.</p> <p>2. On 4/7/15 from 3:10pm until 5:20pm and on 4/8/15 from 5:55am until 8:30am, client #3 sat in a wheel chair without leg rests. Client #3's buttocks, lower body, and upper legs extended off the seat of</p>			

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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	<p>her wheel chair while client #3's back was against the wheel chair seat back. On 4/7/15 at 3:50pm, GHS #1 stated client #3's wheel chair was "over 4 to 5 years" old, had no leg rests because "the leg rests were broken," and client #3's lower body "hung off the edge of the wheel chair seat" because the wheel chair did not fit to client #3's body type. At 3:55pm, GHS #1 and the Residential Manager (RM) both indicated client #3's wheel chair did not fit client #3 to promote mobility.</p> <p>Client #3's record was reviewed on 4/10/15 at 9:30am. Client #3's 3/17/15 ISP indicated she used a wheel chair for mobility and was legally blind. Client #3's ISP indicated a goal for client #3 to set the brakes on her wheel chair for safety. Client #3's 8/21/14 PT (Physical Therapy) assessment indicated client #3 used a wheel chair and to continue exercises for mobility.</p> <p>On 4/10/15 at 10:50am, an interview with the QIDP was conducted. The QIDP stated client #3's wheel chair did not fit her body type, the leg rests were broken, and the wheelchair needed to be replaced.</p> <p>9-3-7(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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W 454  Bldg. 00	<p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility failed to ensure the group home staff implemented sanitary methods and ensured staff followed the recommended care to prevent bacteria growth during the preparation of client #4's tube feeding mixture.</p> <p>Findings include:</p> <p>On 4/7/15 from 3:10pm until 5:20pm, observation and interviews were completed at the group home with client #4. At 4:25pm, GHS (Group Home Staff) #1 assembled client #4's feeding mixture of one (1) package of Carnation Instant Breakfast and one (1) cup Lactose Milk from the refrigerator, stirred the mixture, and placed the mixture in the microwave oven one (1) minute, and heated the mixture. At 1 minute the microwave chimed off, GHS #1 removed the heated mixture, touched the outside of the glass measuring cup with her hand, and indicated the mixture was the correct temperature. GHS #1 walked to the living room, approached client #4 who sat in the living room in a chair, exposed</p>	W 454	<p>On 4-8-15 Nurse assessed client, reviewed all discharge orders, measured blister area on hand, trained staff on orders, and left written nurses orders. Client was evaluated on 4-9-15 by primary physician. On 4-9--10-15, the nurse assessed the client, trained staff on all discharge orders and G tube placement. She tested staff for competency. (see attachment 9,10,11 ) All staff received nurses training on 5/6/15 covering infectious control procedures, and g-tube feeding procedures. (see attachment 29, 30, 31, 32) RM, QDP, Nurse, and Coordinator will monitor staff compliance though daily observations until consistent compliance with procedure is established. Documentation of observations will be reviewed by management/Coordinator weekly. To ensure this deficiency does not occur again, the Coordinator will review this procedure with staff on a monthly basis during house meetings until consistent compliance with the procedure is established. RM, QDP, Nurse, and Coordinator are responsible.</p>	05/17/2015

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	<p>client #4's chest/stomach area, inserted the syringe tip into the end of client #4's stomach tube, and administered his tube feeding.</p> <p>On 4/8/15 from 5:55am until 8:30am, client #4 was observed at the group home. At 7:18am, GHS #2 assembled client #4's feeding mixture of one (1) package of Carnation Instant Breakfast and one (1) cup Lactose Milk, stirred the mixture, and placed the mixture in the microwave oven twenty (20) seconds, and heated the mixture. At 20 seconds the microwave chimed off, GHS #2 removed the heated mixture, touched the mixture with her index finger, and indicated the mixture was the correct temperature. GHS #2 walked to the living room, approached client #4 who sat in the living room in a chair, and administered his tube feeding.</p> <p>Client #4's record was reviewed on 4/8/15 at 9:00am. Client #4's "3/19/15 Fax (a communication from the agency nurse to the group home staff)...Training on G-tube (Gastrostomy Tube-a tube surgically inserted into the stomach for feeding) page 43-44 from Med (Medication) Manual (sic). Also nurses instruction. Also if they place a G-tube Hospital should train 1 or 2 of our staff... (page 43-44) Feeding Tube...Formula</p>			

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPORT, IN 46947
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	<p>should be give at room temperature too hot or cold would make patient uncomfortable. Unused formula should be refrigerated. Refrigerated formula should be warmed to room temperature over a 30 minute period before feeding. Never heat the solution as this could increase the growth of Bacteria (sic)..." signed by the agency nurse.</p> <p>Client #4's 4/6/15 hospital Registered Dietician notes indicated "...Suggested product: Jevity 1.2...Using six feeding periods and a bolus type feeding method the following is suggested...Product should be at room temperature...."</p> <p>On 4/8/15 at 8:45am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4 was admitted to the hospital on 3/18/15 and had a G-tube surgically inserted into his stomach for feeding. The QIDP stated client #4 was "supposed to get Jevity" tube feeding and "our pharmacy" was unable to provide client #4's recommended Jevity feeding. The QIDP stated the staff at the group home called the doctor and he told them to "get a cup of Lactose Milk" from the grocery store, mix the milk with CIB (Carnation Instant Breakfast), and administer the mixture to client #4 by his G-tube. The QIDP</p>			

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 300 S WESTERN LOGANSPOET, IN 46947		
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	indicated staff should have used a sanitary method to check the temperature of the mixture like a thermometer or should have left client #4's mixture out to bring the mixture to room temperature.  9-3-7(a)				