

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/21/2011
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MITCHEL ST ROCHESTER, IN46975
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W0000	<p>This visit was for the pre determined full recertification and state licensure survey.</p> <p>Dates of Survey: December 14, 15, 19, 20, and 21, 2011.</p> <p>Provider Number: 15G698 Facility Number: 003238 AIM Number: 200371780</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12-29-11 by C. Neary, Program Coordinator.</p>	W0000		
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, the governing body failed to exercise operating direction over the facility to ensure clients were not charged for supper as a group in the community, failed to ensure facility staff followed the facility's medication destruction policy and procedure, and failed to ensure chemicals were secured for 4 of 4 sample</p>	W0104	W 104 #1RM will reimburse all consumers that paid for their own meals during Diner Club at the VFW. Any group meal outside of the home will be payed by Cardinal Services if a meal is not also provided at the home. RM and Coordinator will do audits of the group home finances to assure that individuals do not pay for items to be provided by the facility. See attachment MW104 #2LPN will retrain all staff over	01/12/2012

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>clients (clients #1, #2, #3, and#4) living in the group home.</p> <p>Findings include:</p> <p>1. On 12/20/11 at 11:35am, the facility's financial records for client's #1, #2, #3, and #4 were reviewed. At 11:35am, client #1, #2, #3, and #4's financial ledger sheets indicated each clients' personal account was charged \$2.00 for each of the "Diners Club at the VFW (Veterans of Foreign Wars)" restaurant on 12/12/11, 11/14/11, and 10/2011. On 12/20/11 at 11:35am, an interview with the House Manager (HM) and the QDP (Qualified Developmental Disability Professional) was completed. The HM and QDP both stated clients #1, #2, #3, and #4 "all went out to dinner and paid for their supper." Both indicated no supper meal was prepared at the group home on the evenings when the clients went to the VFW to dine.</p> <p>On 12/20/11 at 11:35am, client #1, #2, #3, and #4's record indicated a "Resident Rights" form undated, which indicated the group home rate was "all inclusive" for meals.</p> <p>On 12/20/11 at 11:35am, an interview with the QDP stated the clients should "not be charged for meals" out in the community "when the clients go out to eat</p>		<p>Med Core and the Med distruction Policy at the House meeting on January 12, 2012. See attachment A, B, C. See also attachment O of completed training.QDP, RM and Corrdinator will do monthly and quarterly observations to assure that med distruction policy being followed properly. See attachment NW104 #3All chemicals in the group home will be locked up. QDP will retrain staff over Client #1's Risk Plan and BMP on January 12, 2012 during the house meeting. See Attachment D and E. See also attachment O of completed training.Surveyor indicated that client's #1 and #4 also had an identified need for chemicals to be locked based on review of their ISP's and Risk assesment. Client #1 does have PICA but has never attempted to injest chemicals. Client #4 has not ever attempted to injest chemicals in the group home. QDP did review Client 1 and 4's risk assesment and both indicat that Chemicals are locked up for the safety of another individual living in their home.</p>		

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	<p>together."</p> <p>2. During both observations on 12/14/11 from 12noon until 12:18pm, and on 12/15/11 from 6:10am until 7:25am, medication administration was completed and a "Maxwell House" coffee container was observed on the ladies side of the group home inside the medication room. On 12/14/11 at 12noon, DCS (Direct Care Staff) #1 stated and client #2's 12/2011 MAR (Medication Administration Record) indicated the medications of "Phenobarbital 32mg (milligrams) tablet (for seizures) 1 tablet three times a day (and) Keppra 1000mg (for seizures) 1 tablet 3 x daily (three times a day)" into a medication cup. DCS #1 selected the medication from a double locked secure box inside the medication cabinet. DCS #1 poured client #2's medications from the cup into a small dessert bowl of apple sauce, attempted to feed the mixture to client #2, and client #2 refused the medications multiple times. At 12:18pm, DCS #1 selected a "Maxwell House" coffee container on the shelf inside the the med room and on the top of the plastic lid was "meds (medications)." DCS #1 opened the canister, DCS #1 stated the "offensive" smell filled the room, and DCS #1 poured client #2's medications into the black tar looking paste which had "flecks" of yellow and white visible in</p>				

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	<p>contrast to the black tar matter. When asked: What was in the Maxwell House coffee container? DCS #1 stated "Coffee" and "other stuff." When asked: What medications were already in the container before DCS #1 added client #2's Phenobarbital and Keppra? DCS #1 stated "I have no idea, we've (we have) used that (container) for a while now." DCS #1 indicated there was no documentation to determine what was inside the Maxwell House coffee container for destroyed medications. DCS #1 stated "we were told we can't flush refused medications anymore, so the agency said to do it this way." DCS #1 returned the Maxwell House coffee container back on the shelf inside the medication room.</p> <p>On 12/15/11 from 6am until 8:07am, at the group home, the Maxwell House coffee container inside the ladies side medication room was observed sitting on a shelf and not behind two secure locks.</p> <p>On 12/20/11 at 11:45am, an interview with the agency LPN (Licensed Practical Nurse) was completed. The LPN indicated the agency followed Core A/Core B medication training for medication administration. The LPN stated she had "not been contacted by the group home staff" of client #2's refusals</p>				

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	<p>on 12/14/11 to take her medications and was "unaware" that the facility staff were putting discarded medications "into a coffee can." The LPN stated "at the very least the coffee can should have been doubled locked." The LPN stated "the medications destroyed were controlled medications" and stated controlled medications "required" two locks for security. The LPN stated the staff did not "follow the medication destruction policy."</p> <p>On 12/20/11 at 1:05pm, a record review was completed of the "Living in the Community Medication Administration Manual," dated 2004, which indicated "...It is a condition of employment that each staff member be able to accurately and safely administer medications. Living in the Community (LIC) training [Core A and Core B training]...[page 31] Controlled Substance Act of 1970 established five schedules for all controlled substance, drugs that are addictive or habit forming...The Controlled Substance Act requires special precautions. Controlled substances must be accounted for by the agency, and must be double locked and counted regularly...."</p> <p>On 12/20/11 at 1:05pm, a record review of the the agency's 11/2011 "Medication</p>				

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	<p>Policy" indicated controlled substances "must" be double locked at "all times...Medication Disposal In the event a medication is discontinued, the following procedure will be followed, place the medication in a secured area in the med closet to be given to the nurse or returned to the pharmacy...The nurse will be responsible for securing all topical and liquid medications at least quarterly...Medications not in the punch pack that has been refused, dropped, or spit out will be disposed of by two staff by flushing down the toilet or rinsed down the sink and properly documented on the Destruction of Medication record..."</p> <p>3. On 12/14/11 from 11:40am until 1:45pm, and on 12/15/11 from 6am until 8:07am, the mens side bathroom cabinet shelf had a 28oz. (ounce) bottle of "The Works" toilet bowl cleaner and a 19oz. can of spray disinfectant at eye level. On 12/15/11 at 6:45am, an interview with DCS (Direct Care Staff) #2 and DCS #3 stated clients #1, #3, and #4 were at risk and "had histories" of "inappropriate use of chemicals." DCS #3 stated client #3 "would drink toilet bowl cleaner or disinfectant" cleaners.</p> <p>On 12/20/11 at 11:10am, client #1's record indicated he needed chemicals secured out of reach. Client #1's 10/27/11</p>						

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	<p>ISP (Individual Support Plan) and 10/27/11 "Risk Assessment" indicated client #1 needed chemicals kept secured.</p> <p>On 12/20/11 at 11am, client #3's record indicated he needed chemicals secured out of reach because he had ingested chemicals in the past. Client #3's 7/28/11 ISP indicated a goal to identify chemical containers and client #3's 7/28/11 "Risk Assessment" indicated client #3 needed chemicals kept secured.</p> <p>On 12/20/11 at 10:40am, client #4's record indicated he needed chemicals secured out of reach because he had misused chemicals in the past. Client #4's 10/25/11 ISP and 10/25/11 "Risk Assessment" indicated client #4 needed chemicals kept secured.</p> <p>On 12/20/11 at 11:35am, an interview with the HM, QDP, and agency nurse was completed. The three indicated clients #1, #3, and #4 had an identified need for locked chemicals because of their history of ingestion and misuse. The three indicated chemicals should have been secure and locked at the group home.</p> <p>9-3-1(a)</p>				

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W0137	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, record review, and interview, for 1 of 4 sample clients (client #3), the facility failed to allow client #3 unimpeded access to his personal hygiene supplies and tote.</p> <p>Findings include:</p> <p>On 12/15/11 at 7:10am, client #3's personal hygiene tote which contained client #3's comb, electric razor, tooth brush, tooth paste, and hair brush were locked inside the medication room and sat on the shelf. On 12/15/11 at 7:10am, DCS #1 indicated the secured tote was client #3's and did not indicate why it was kept secured.</p> <p>On 12/20/11 at 11:45am, an interview with the QDP (Qualified Development Disability Professional) and the HM (House Manager) was completed. Both stated client #3's personal hygiene tote should "not have been" inside the locked medication room. Both indicated client #3 did not have unimpeded access to his personal supplies.</p> <p>Client #3's records were reviewed on</p>	W0137	W137QMRP will train staff over tag 137 Client Rights at the house meeting on January 12, 2012. See Attachment F. See also attachment O of completed training. QDP, RM and Corrdinator will do monthly and quarterly observations to assure that clients are able to retain personal possessions on an ongoing basis. See attachment N	01/12/2012	

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W0227	<p>12/20/11 at 11am. Client #3's 7/28/11 ISP and record did not indicate an identified need for secured personal items.</p> <p>9-3-2(a) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review, and interview for 1 of 4 sampled clients (client #1) who lived in the group home, the facility failed to initiate programming in client #1's Individual Support Plan (ISP) to include client #1's identified property destruction behaviors.</p> <p>Findings include:</p> <p>During observations on 12/14/11 from 11:40am until 1:45pm, at the group home client #1 was observed to punch with his left and right hands the plexi glass covered television set two hundred and nine times (209 times) in the men's side living room without redirection. From 11:40am until 1:45pm, DCS (Direct Care Staff) #1, DCS #4, DCS #5, and DCS #6 were observed to walk by client #1 and did not offer activity or redirection after he hit, punched, and shook the television.</p> <p>On 12/20/11 at 11:10am, client #1's</p>	W0227	W 227QDP updated client #1's Behavior Managment Plan to include interventions for property distruction and updated behavior tracking chart to include property distruciton. QDP will train staff over updated Behavior Managment Plan and updated behavior tracking chart to include property distruciton at the house meeting on January 12, 2012. See attachment G and H. See also attachment O of completed training.QDP, RM and Corrdinator will do monthly and quarterly observations to ensure that indentified needs are assessed and addressed as patterns of behaviors become apparent. See attachment N	01/12/2012			

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W0240	<p>record indicated a 10/27/11 ISP (Individual Support Plan) and a 4/2011 BSP (Behavior Support Plan). Client #1's ISP and BSP did not identify his behavior of hitting, punching, or shaking the television.</p> <p>On 12/20/11 at 11:45am, an interview with the HM (House Manager) and QDP (Qualified Developmental Disability Professional) was completed. Both indicated client #1 had behaviors of hitting the television and stated "that's why it has plexi glass" covering the television. The HM stated "boy it was loud when he hit it that day." The QDP indicated client #1's ISP and BSP did not include his physically aggressive behaviors towards property or property destruction.</p> <p>9-3-4(a) The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review, and interview for 2 of 3 sampled clients (clients #2 and #4) who used adaptive devices, the facility failed to initiate programming in client #2 and #4's Individual Support Plan (ISP) to address health care supports.</p>	W0240	W240 #1QDP updated client #2's ISP and schedule of use to include the use of a stool or footrest. QDP will train staff over updated schedule of use for client #2's footrest or stool at the house meeting on January 12, 2012. See Attachment I and J. See also attachment O of completed training.W240 #2QDP will retrain staff over Client #4's fall	01/12/2012	

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	<p>Findings include:</p> <p>1. During observations on 12/14/11 from 11:40am until 1:45pm, at the group home client #2 was observed to sit in a wheel chair and her feet did not touch the floor. Throughout the observation period client #2 sat in her wheel chair, ate her lunch, watched television, listened to a story read by staff, and client #2's feet/legs dangled from the sitting position in her wheel chair and did not touch the floor. From 11:40am until 1:45pm, DCS #1, DCS #4, DCS #5, and DCS #6 were observed to walk by client #2 and did not offer foot supports or interventions to support client #2's feet.</p> <p>On 12/20/11 at 10:25am, client #2's record was reviewed. Client #2's 5/24/11 ISP and 5/24/11 "Risk Assessment" did not indicate the need for foot/leg supports. Client #2's ISP and Risk Assessment indicated client #2 was dependent on facility staff to transfer her and to reposition her every two (2) hours.</p> <p>On 12/20/11 at 11:45am, an interview with the HM, the agency nurse, and QDP was completed. The three indicated client #2 was dependent on staff to offer her foot/leg supports when she sat a long time in the wheel chair. The agency nurse stated client #2 should have had a foot</p>		<p>prevention plan and schedule of use regarding the use of a gait belt on January 12, 2012. See Attachment K and L. See also attachment O of completed training. For all clients affected by this tag a schedule of use has been put in place so that staff know when the adaptive equipment should be used. QDP, RM and Corrdinator will do monthly and quarterly observations to assure adaptive equipment is being used based on the schedule of use and observe for all other identified needs. See attachment N</p>		

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	<p>stool or leg/foot rests on her wheel chair when client #2's feet did not touch the floor. The agency nurse indicated client #2 had experienced a medical decline over the past year and was using her wheel chair more than she had before. The agency nurse indicated client #2's record did not indicate the use of foot/leg supports and stated "but staff should have known" to use them for client #2's feet.</p> <p>2. During observations on 12/14/11 from 11:40am until 1:45pm, at the group home client #4 was observed to sit in a rigid chair, the toilet, and on the sofa. Each time client #4 was assisted up by two staff under his arms to a standing position and to walk throughout the group home arm in arm with staff. From 11:40am until 1:45pm, DCS #1, DCS #4, DCS #5, and DCS #6 were observed to assist client #4 by his arms and no gait belt was observed used.</p> <p>On 12/15/11 at 9am, the facility's BDDS (Bureau of Developmental Disability Services) reports were reviewed and indicated the following. -On 9/1/11 at 4pm, client #4 was "being assisted out of a chair and staff heard a pop." The report indicated client #4 was taken to the emergency room (ER). The ER report and 9/1/11 X-ray both indicated client #4 was seen for shoulder pain and</p>				

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W0249	<p>X-ray was negative "but showed severe left joint degenerative changes."</p> <p>On 12/20/11 at 11:45am, an interview with the HM, the agency nurse, and QDP was completed. The three indicated client #4 was dependent on staff to raise to a standing position. The agency nurse stated "they should have used a gait belt with him and it wasn't in his documents to use it."</p> <p>On 12/20/11 at 10:40am, client #4's record was reviewed. Client #4's record did not indicate the use of supports to prevent further injuries to his left shoulder joint. Client #4's 10/25/11 ISP and 10/25/11 "Risk Assessment" did not indicate the need for a gait belt. Client #4's ISP and Risk Assessment indicated client #4 was dependent on facility staff to get to a standing position from a sitting position.</p> <p>9-3-4(a) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and</p>	W0249	W249QDP will retrain staff over client # 3's risk plan and behavior managment plan on January 12,	01/12/2012	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>interview, for 3 of 4 clients (clients #1, #3, and #4) who lived on the men's side of the group home, the facility failed to implement formal and informal opportunities to teach clients chemical security.</p> <p>Findings include:</p> <p>On 12/14/11 from 11:40am until 1:45pm, and on 12/15/11 from 6am until 8:07am, the mens side bathroom cabinet shelf had a 28oz. (ounce) bottle of "The Works" toilet bowl cleaner and a 19oz. can of spray disinfectant at eye level. On 12/15/11 at 6:45am, an interview with DCS (Direct Care Staff) #2 and DCS #3, stated clients #1, #3, and #4 were at risk and "had histories" of "inappropriate use of chemicals." At 6:45am, DCS #3 stated client #3 "would drink toilet bowl cleaner or disinfectant" cleaners. At 6:45am, DCS #2 indicated clients #1, #3, and #4 needed chemicals secured because the clients did not recognize the dangers of chemicals.</p> <p>On 12/20/11 at 11:10am, client #1's 10/27/11 ISP (Individual Support Plan) and 10/27/11 "Risk Assessment" indicated client #1 needed chemicals kept secured. Client #1's ISP and Risk Assessment both indicated the need for chemicals to be secured out of reach.</p>		<p>2012 at the house meeting. See Attachment D and E. See also attachment O of completed training. Surveryor indicated that client's #1 and #4 also had an identified need for chemicals to be locked based on review of their ISP's and Risk assesment. Client #1 does have PICA but has never attempted to inject chemicals. Client #4 has not ever attempted to inject chemicals in the group home. QDP did review Client 1 and 4's risk assesment and both indicat that Chemicals are locked up for the safety of another individual living in their home. There is no identified need for Clients 1 and 4 to have chemicals locked up and this is not in their risk plans, isp's, or behavior plans. A informal goal will be added that once a week each individual will be trained on how to retrieve chemcials such as cleaning supplies as needed. This will be tracked on an informal training sheet. QDP, RM, and Coordinator will conduct monthly and quarterly observations to assure that goals are being ran and plans are being followed. See attachment N</p>		

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	<p>On 12/20/11 at 11am, client #3's 7/28/11 ISP indicated a goal to identify chemical containers and client #3's 7/28/11 "Risk Assessment" indicated client #3 needed chemicals kept secured. Client #3's ISP and Risk Assessment both indicated client #3 needed chemicals secured out of reach because he had ingested chemicals in the past.</p> <p>On 12/20/11 at 10:40am, client #4's 10/25/11 ISP and 10/25/11 "Risk Assessment" indicated client #4 needed chemicals kept secured. Client #4's ISP and Risk Assessment both indicated he needed chemicals secured out of reach because he had misused chemicals in the past.</p> <p>On 12/20/11 at 11:35am, an interview with the HM, QDP, and agency nurse was completed. The three indicated clients #1, #3, and #4 had an identified need for locked chemicals because of their history of ingestion and misuse. The three indicated chemicals should have been secure and locked at the group home.</p> <p>9-3-4(a)</p>				