

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1207 W WINONA AVE WARSAW, IN 46580		
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W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: October 2, 3, 7, 8, 9, and 10, 2013.</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>Facility number: 000881 Provider number: 15G367 AIM number: 100249180</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed on 10/23/13 by W. Chris Greeney QIDP</p>	W000000			

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

TITLE

(X6) DATE

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

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review, and interview, the facility neglected to implement policy and procedures to protect 3 of 4 sampled clients (clients #2, #3 and #4) and 3 additional clients (clients #5, #6 and #8) from physical aggression resulting in injury.</p> <p>Findings include:</p> <p>The facility's accident and incident reports from March, 2013 to October, 2013 were reviewed on 10/2/13 at 2:40 PM and indicated the following:</p> <p>On 4/21/13 at 2:00 PM, client #4 was standing in the kitchen and client #7 "grabs his collar leaving a scratch (size and location not indicated)." Steps to prevent similar accidents in the future indicated "Nails looked trimmed so I don't know how this could have been prevented."</p> <p>On 4/21/13 at 5:30 PM, client #5 was moving chairs to sweep and client #7 "came up behind him and grabbed his collar leaving a 1/2 inch scratch." Steps to prevent similar accidents in the future</p>	W000149	<p>W149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Per "Incident/Abuse/Neglect Policy Persons Served" Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. The support staff at the West Winona group home received additional training regarding this policy on 11/1/13 (see attachment A). Specifically, they were trained on following Person Served revised plans as written (see attachment D.) To ensure that the people that receive services through Cardinal Services have effective, timely supports QDP's were trained to recognize patterns of behavior and to take the appropriate steps to seek addition supports when these trends occur. (see attachment B)</p> <p>Cardinal will ensure ongoing compliance with this regulation by, review of observations and documentation completed by residential managers, coordinators, QDPs and support personnel. Observations are done daily by the shift manager, weekly by the residential manager, monthly by the QDP, and quarterly by the coordinator.</p>	11/09/2013			

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	<p>indicated "I don't know how this could have been prevented, his nails looked very short already."</p> <p>On 4/22/13 at 5:30 PM, "as [client #2] walking (sic) down the hallway, [client #7] grabbed his shirt and scraping (sic) his nails against his skin causing 1 inch sized scratch near his left shoulder. Steps to prevent similar accidents in the future indicated "Try to prevent [client #7] from grabbing the shirts of his peers."</p> <p>On 4/22/13 at 2:45 PM client #6 "was sitting in the living room sleeping [client #7] came in to the room and grabbed his shirt collar resulting in scratches." Steps to prevent similar accidents in the future indicated "Keep better idea where [client #7] is so this doesn't happen."</p> <p>On 5/5/13 at 8:15 PM, client #5 "was waiting for meds (medications) when a peer (unidentified) reached up and grabbed his collar resulting in 3 scratch marks in the middle of his back." The report indicated the clients' self management plans were implemented, the accident was preventable. In a section titled "What could have been done differently to prevent it from happening?", the report indicated "Very hard to prevent unless the peer is within arm's reach of staff at all times."</p>		Coordinator, Manager and QDPs Responsible				

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	<p>On 5/25/13 at 6:30 PM client #6 was sitting in the living room "waiting for 8:30 PM meds. [Client #7] walked in sat next to [client #6's] chair and grabbed his left leg. Staff got him to let go and he immediately grabbed [client #6's] right forearm. (sic) Leaving pinch marks on [client #6's] leg and scratch marks on his arm." Steps to prevent similar accidents in the future indicated "Not have so many new subs (substitute contracted staff) in and out of the house in one day."</p> <p>On 5/26/13 at 6:00 PM, client #5 "was in the dining room assisting with laundry. [Client #7] came up behind him and grabbed the back of his shirt, leaving scratch marks on the back of his neck area." Steps to prevent similar accidents in the future indicated "Not have so many subs in and out of the house in one day."</p> <p>On 6/2/13 at 2:15 PM client #4 was standing in the kitchen and client #7 "grabs his arm. Staff intervenes and notices [client #4] has a one inch scratch on his elbow." Steps to prevent similar accidents in the future indicated "Nails look trimmed so I don't know how this could have been prevented."</p> <p>On 6/11/13 at 6:50 PM, "As staff were redirecting [client #7], he reached out and</p>			

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	<p>caught [client #2's] arm and left three 1 inch scratches on the bend of [client #2's] arm." Steps to prevent similar accidents in the future indicated "Nails looked trimmed, do not know how it could have been prevented."</p> <p>On 6/13/13 at 6:45 PM "[Client #8] was coming into the kitchen when one of his peers (unidentified) grabbed his left arm, leaving behind 2 scratch marks." Steps to prevent similar accidents in the future indicated "to try and trim the guys nails and to file them as much as we can."</p> <p>On 6/21/13 at 7:50 PM, "Staff was giving meds to a peer when they heard [client #5] yell. They opened the door and found that [client #7] had grabbed his shirt. When staff undid [client #7's] fingers from the shirt they noticed 3 long scratches. Staff washed them with soap and water." Steps to prevent similar accidents in the future indicated "Staff filed [client #7's] nails to see if that could help. [Client #7] is looking for someone to be totally 1 on 1 with him."</p> <p>On 6/30/13 at 6:00 PM, client #3 was sitting relaxing when a peer (unidentified) came up and grabbed [client #3's] shirt while scratching his right shoulder/neck area." Steps to prevent similar accidents in the future indicated "There is no way to</p>			

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	<p>prevent because it was an unprovoked attack."</p> <p>On 7/3/13 at 7:00 PM, staff was cleaning the kitchen after dinner and a peer (unidentified) came up and grab (sic) the collar of [client #4's] shirt while staff had her back turned. The peer (unidentified) had one scratch mark along the back of his neck. Steps to prevent similar accidents in the future indicated "Staff needs to be made aware of named peer is entering a room where other peers are present."</p> <p>On 7/6/13 at 4:45 PM, client #6 was sitting in the living room when he was grabbed by his peer (unidentified). As staff were removing his hand from [client #6's] arm a 1/2 inch scratch was left on his arm. Steps to prevent similar accidents in the future indicated "I donn't (sic) know."</p> <p>On 7/8/13 at 5:30 PM, client #6 "was in the kitchen waiting for dinner, and a peer (unidentified) came up and grabbed his arm leaving a scratch." Steps to prevent similar accidents in the future indicated "Staff needed to be made aware that the specific peer was entering the room."</p> <p>On 7/20/13 at 4:00 PM, client #3 was observing dinner prep when his peer</p>			

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	<p>grabbed his collar before staff could get to him ans (sic) scratched his neck (size not indicated). Steps to prevent similar accidents in the future indicated "His fingernails were short and filed in the morning. All other staff were busy at this time leaving one staff in the kitchen preparing dinner."</p> <p>On 8/31/13 at 6:30 PM, client #5 "was standing by staff when a peer came up behind him and grabbed his collar leaving 2 scratches." Steps to prevent similar accidents in the future indicated "Be more mindful of where peers are."</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 10/3/13 at 12:55 PM. When asked about revisions to client #7's plan, she indicated the plan had been changed to keep client #7 within arm's length on July 19, 2013.</p> <p>Client #7's records were reviewed on 10/3/13 at 1:10 PM. A Self Management Plan dated November, 2012 indicated target behaviors of physical aggression, elopement (AWOL) (away without leave), urination/defecation, pica, regurgitation, inappropriate eating, self stimulation and spitting. The plan indicated when client #7 attempted "to grab someone's hands, clothing, or hair, staff should block the attempt by placing my wrist between their</p>						

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	thumb and forefinger (without closing their fingers around my wrist). When this is done, I can twist and turn my hand, but will be unable to get a grasp on the person. When I successfully get a hold of an individual's clothing or body parts, staff should begin by gently placing their hand over the top of my hand to ensure that I do not pull the individual over or rip their clothing." If needed, staff were to roll their fingers out and up to remove client #7's fingers from the object and "first and foremost for if you know what the antecedent behaviors are are to watch for them. When I demonstrate them intervene and redirect my attention to a positive activity...Staff should physically block me from being aggressive by gently placing their hands over mine to keep me from pinching or hitting. If the individual I am targeting is another person served it is important to separate me from that individual to ensure their safety and mine in case of retaliation." Client #7 was to be physically assisted to a safe location where client #7 can "calm down and have no one to target." Human Rights Approval Documentation dated 4/11/13 indicated client #7 had been "showing an increase in aggression towards his peers in the home. He is more aggressively grabbing and scratching peers causing injury to others. [Dr.] has recommended starting him on Trilepal to be used as a						

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	<p>mood stabilizer to help with the aggressions."</p> <p>Client #7's IDT (interdisciplinary team) notes dated 7/19/13 were reviewed on 10/3/13 at 1:13 PM and indicated client #7 has been showing an increase in grabbing and pinching other individuals in the home. The team met to discuss what staff can do to help decrease the amount of occurrences that are happening," and indicated client #7 was now to be "within staff arm's length reach at all times while he is awake so staff are able to redirect him from grabbing his peers in the home." IDT notes dated 3/27/13 indicated client #7 "has been showing an increase in aggression while using the finger control mitts. While using the mitts, [client #7] becomes more aggressive and he begins to hit with them on as well as taking them off and pinching peers and staff more frequently." The notes indicated the use of finger control mitts would be discontinued, and "the team will continue to monitor to see if this is helping assist in a decrease in occurrences. If this is appearing as not working the team will meet to reevaluate." Included with the notes was an undated Finger Control Mitts Plan that included the use of mitts once client #7 attempted to grab staff or clients three times. The mitts were to be worn for 30</p>						

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	<p>minutes and removed. If client #7 attempted to "grab staff or peers three times after this, staff should put the mitts back on and start the 30 minutes over."</p> <p>Client #7's behavior rates for the period of December, 2012 to August, 2013 were reviewed on 1/13/13 at 1:07 PM. Rates for physical aggression indicated: 15 in September, 2012, 72 in October 2012, 38 in November, 2012, 24 in December, 2012, 2 in January, 2012, 42 in February, 2012, 38 in March, 2012, 37 in April, 2013, 28 in July, 2013, and 32 in August, 2013. Client #</p> <p>The QDP was was interviewed on 10/3/13 at 1:15 PM. At each example where there was an unidentified peer, the QIDP indicated the unidentified peer was client #7.</p> <p>The Adult Services Director was interviewed on 10/7/13 at 12:51 PM. She indicated the facility had not been able to prevent client #7's physical aggression resulting in injury prior to August 31, 2013, but the revision to client #7's plan to keep him within arm's length of staff as of July, 19, 2013 had been effective in preventing further injuries. She indicated the facility had been attempting the least restrictive methods to address client #7's behaviors and give the plan time to work.</p>						

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	<p>The facility's policy and procedures "Cardinal Services, Inc. Incident/Abuse/Neglect Policy Persons Served dated 5/13 was reviewed on 10/2/13 at 12:30 PM and indicated in part, "Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect or exploitation of persons served by staff members, other persons served, or others will not be tolerated; incidents will be reported and thoroughly investigated..." Physical Abuse/Sexual Abuse was defined as "...willful infliction of injury, by hitting, pinching, or kicking, physical restraints...Neglect was defined as "Incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his or her life or health...)." <p>9-3-2(a)</p> </p>						

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review, and interview, the facility neglected to implement effective corrective action to protect 3 of 4 sampled clients (clients #2, #3 and #4) and 3 additional clients (clients #5, #6 and #8) from physical aggression resulting in injury involving 17 of 39 accident/incident reports reviewed.</p> <p>Findings include:</p> <p>The facility's accident and incident reports from March, 2013 to October, 2013 were reviewed on 10/2/13 at 2:40 PM and indicated the following:</p> <ol style="list-style-type: none"> 1. On 4/21/13 at 2:00 PM, client #4 was standing in the kitchen and client #7 "grabs his collar leaving a scratch (size and location not indicated)." Steps to prevent similar accidents in the future indicated "Nails looked trimmed so I don't know how this could have been prevented." 2. On 4/21/13 at 5:30 PM, client #5 was moving chairs to sweep and client #7 "came up behind him and grabbed his collar leaving a 1/2 inch scratch." Steps to prevent similar accidents in the future 	W000157	W157 If the alleged violation is verified, appropriate corrective action must be taken. Cardinal Services, Inc. is committed to providing quality services in a safe environment which is free from abuse, neglect and mistreatment for the people that we provide supports for. To ensure that client # 7 receives effective supports and that Clients #2, #3, #4, #5, #6 and #8 are free from physical aggression from their peer, Cardinal Services obtained outside behavior specialist services for Client #7with the initial meeting being held on October 9, 2013. (see attachment C) The specialist will assess Client #7's needs, write a support plan and train Cardinal Services' staff on implementation and monitoring criteria. To provide for the protection of Clients #2, #3, #4, #5, #6 and #8 in the interim, staff in the West Winona group home received additional training regarding Client #7's support plan outlining a schedule of staff responsibility. (see attachment D) and stating that staff will stay within arm's length and position themselves in-between Client #7 and his peers. (see attachment E) In addition a monthly analysis of all accidents, injuries and incidents is conducted by department	11/09/2013			

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	<p>indicated "I don't know how this could have been prevented, his nails looked very short already."</p> <p>3. On 4/22/13 at 5:30 PM, "as [client #2] walking (sic) down the hallway, [client #7] grabbed his shirt and scraping (sic) his nails against his skin causing 1 inch sized scratch near his left shoulder. Steps to prevent similar accidents in the future indicated "Try to prevent [client #7] from grabbing the shirts of his peers."</p> <p>4. On 4/22/13 at 2:45 PM client #6 "was sitting in the living room sleeping [client #7] came in to the room and grabbed his shirt collar resulting in scratches." Steps to prevent similar accidents in the future indicated "Keep better idea where [client #7] is so this doesn't happen."</p> <p>5. On 5/5/13 at 8:15 PM, client #5 "was waiting for meds (medications) when a peer (unidentified) reached up and grabbed his collar resulting in 3 scratch marks in the middle of his back." The report indicated the clients' self management plans were implemented, the accident was preventable. In a section titled "What could have been done differently to prevent it from happening?", the report indicated "Very hard to prevent unless the peer is within arm's reach of staff at all times."</p>		<p>coordinators to assess for patterns and to ensure preventative/corrective action is taken. (see attachment F) To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the staff performance through weekly, monthly and quarterly observations. Department Coordinators will continue to perform analysis of accident, injury and behavioral data to assess for trends. QMRP, Residential Manager and Residential Coordinator Responsible</p>				

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	<p>6. On 5/25/13 at 6:30 PM client #6 was sitting in the living room "waiting for 8:30 PM meds. [Client #7] walked in sat next to [client #6's] chair and grabbed his left leg. Staff got him to let go and he immediately grabbed [client #6's] right forearm. (sic) Leaving pinch marks on [client #6's] leg and scratch marks on his arm." Steps to prevent similar accidents in the future indicated "Not have so many new subs (substitute contracted staff) in and out of the house in one day."</p> <p>7. On 5/26/13 at 6:00 PM, client #5 "was in the dining room assisting with laundry. [Client #7] came up behind him and grabbed the back of his shirt, leaving scratch marks on the back of his neck area." Steps to prevent similar accidents in the future indicated "Not have so many subs in and out of the house in one day."</p> <p>8. On 6/2/13 at 2:15 PM client #4 was standing in the kitchen and client #7 "grabs his arm. Staff intervenes and notices [client #4] has a one inch scratch on his elbow." Steps to prevent similar accidents in the future indicated "Nails look trimmed so I don't know how this could have been prevented."</p> <p>9. On 6/11/13 at 6:50 PM, "As staff were redirecting [client #7], he reached out and</p>			

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	<p>caught [client #2's] arm and left three 1 inch scratches on the bend of [client #2's] arm." Steps to prevent similar accidents in the future indicated "Nails looked trimmed, do not know how it could have been prevented."</p> <p>10. On 6/13/13 at 6:45 PM "[Client #4] was coming into the kitchen when one of his peers (unidentified) grabbed his left arm, leaving behind 2 scratch marks." Steps to prevent similar accidents in the future indicated "to try and trim the guys nails and to file them as much as we can."</p> <p>11. On 6/21/13 at 7:50 PM, "Staff was giving meds to a peer when they heard [client #5] yell. They opened the door and found that [client #7] had grabbed his shirt. When staff undid [client #7's] fingers from the shirt they noticed 3 long scratches. Staff washed them with soap and water." Steps to prevent similar accidents in the future indicated "Staff filed [client #7's] nails to see if that could help. [Client #7] is looking for someone to be totally 1 on 1 with him."</p> <p>12. On 6/30/13 at 6:00 PM, client #3 was sitting relaxing when a peer (unidentified) came up and grabbed [client #3's] shirt while scratching his right shoulder/neck area." Steps to prevent similar accidents in the future indicated "There is no way to</p>						

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	<p>prevent because it was an unprovoked attack."</p> <p>13. On 7/3/13 at 7:00 PM, staff was cleaning the kitchen after dinner and a peer (unidentified) came up and grab (sic) the collar of [client #4's] shirt while staff had her back turned. The peer (unidentified) had one scratch mark along the back of his neck. Steps to prevent similar accidents in the future indicated "Staff needs to be made aware of named peer is entering a room where other peers are present."</p> <p>14. On 7/6/13 at 4:45 PM, client #6 was sitting in the living room when he was grabbed by his peer (unidentified). As staff were removing his hand from [client #6's] arm a 1/2 inch scratch was left on his arm. Steps to prevent similar accidents in the future indicated "I donn't (sic) know."</p> <p>15. On 7/8/13 at 5:30 PM, client #6 "was in the kitchen waiting for dinner, and a peer (unidentified) came up and grabbed his arm leaving a scratch." Steps to prevent similar accidents in the future indicated "Staff needed to be made aware that the specific peer was entering the room."</p> <p>16. On 7/20/13 at 4:00 PM, client #3 was</p>						

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	<p>observing dinner prep when his peer grabbed his collar before staff could get to him ans (sic) scratched his neck (size not indicated). Steps to prevent similar accidents in the future indicated "His fingernails were short and filed in the morning. All other staff were busy at this time leaving one staff in the kitchen preparing dinner."</p> <p>17. On 8/31/13 at 6:30 PM, client #5 "was standing by staff when a peer came up behind him and grabbed his collar leaving 2 scratches." Steps to prevent similar accidents in the future indicated "Be more mindful of where peers are."</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 10/3/13 at 12:55 PM. When asked about revisions to client #7's plan to address his physically aggressive behaviors, she indicated the plan had been changed to keep client #7 within arm's length on July 19, 2013.</p> <p>Client #7's records were reviewed on 10/3/13 at 1:10 PM. A Self Management Plan dated November, 2012 indicated target behaviors of physical aggression, elopement (AWOL) (away without leave), urination/defecation, pica, regurgitation, inappropriate eating, self stimulation and spitting. The plan indicated when client</p>						

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	#7 attempted "to grab someone's hands, clothing, or hair, staff should block the attempt by placing my wrist between their thumb and forefinger (without closing their fingers around my wrist). When this is done, I can twist and turn my hand, but will be unable to get a grasp on the person. When I successfully get a hold of an individual's clothing or body parts, staff should begin by gently placing their hand over the top of my hand to ensure that I do not pull the individual over or rip their clothing." If needed, staff were to roll their fingers out and up to remove client #7's fingers from the object and "first and foremost for if you know what the antecedent behaviors are are to watch for them. When I demonstrate them intervene and redirect my attention to a positive activity...Staff should physically block me from being aggressive by gently placing their hands over mine to keep me from pinching or hitting. If the individual I am targeting is another person served it is important to separate me from that individual to ensure their safety and mine in case of retaliation." Client #7 was to be physically assisted to a safe location where client #7 can "calm down and have no one to target." Human Rights Approval Documentation dated 4/11/13 indicated client #7 had been "showing an increase in aggression towards his peers in the home. He is more aggressively			

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	<p>grabbing and scratching peers causing injury to others. [Dr.] has recommended starting him on Trilepal to be used as a mood stabilizer to help with the aggressions."</p> <p>Client #7's IDT (interdisciplinary team) notes dated 7/19/13 were reviewed on 10/3/13 at 1:13 PM and indicated client #7 has been showing an increase in grabbing and pinching other individuals in the home. The team met to discuss what staff can do to help decrease the amount of occurrences that are happening," and indicated client #7 was now to be "within staff arm's length reach at all times while he is awake so staff are able to redirect him from grabbing his peers in the home." IDT notes dated 3/27/13 indicated client #7 "has been showing an increase in aggression while using the finger control mitts. While using the mitts, [client #7] becomes more aggressive and he begins to hit with them on as well as taking them off and pinching peers and staff more frequently." The notes indicated the use of finger control mitts would be discontinued, and "the team will continue to monitor to see if this is helping assist in a decrease in occurrences. If this is appearing as not working the team will meet to reevaluate." Included with the notes was an undated Finger Control Mitts Plan that</p>						

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	<p>included the use of mitts once client #7 attempted to grab staff or clients three times. The mitts were to be worn for 30 minutes and removed. If client #7 attempted to "grab staff or peers three times after this, staff should put the mitts back on and start the 30 minutes over."</p> <p>Client #7's behavior rates for the period of December, 2012 to August, 2013 were reviewed on 1/13/13 at 1:07 PM. Rates for physical aggression indicated: 15 in September, 2012, 72 in October 2012, 38 in November, 2012, 24 in December, 2012, 2 in January, 2012, 42 in February, 2012, 38 in March, 2012, 37 in April, 2013, 28 in July, 2013, and 32 in August, 2013.</p> <p>The QDP was interviewed on 10/3/13 at 1:15 PM. At each example where there was an unidentified peer, the QIDP indicated the unidentified peer was client #7.</p> <p>The Adult Services Director was interviewed on 10/7/13 at 12:51 PM. She indicated the facility had not been able to prevent client #7's physical aggression resulting in injury prior to August 31, 2013. She indicated the facility had been attempting the least restrictive methods to address client #7's behaviors and give the plan time to work.</p>						

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W000164	<p>483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.</p> <p>Based on record review, observation and interview for 1 of 4 sampled clients (client #1), and 1 additional client (client #7) the facility failed to assure the professional program services clinician (behavioral consultant) was available in the group home to develop and ensure implementation of plans to address physically aggressive behavior.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/2/13 at 2:40 PM. The following reports involved client #1 requiring physical restraint to address his behaviors of physical aggression and elopement:</p> <p>1. A BDDS report dated 9/26/12 indicated client #1 "started yelling and ran out the front door." Client #1 exited the front porch and entered into the driveway. Client #1 attempted to "continued to push through staff in the driveway towards the road while yelling and cussing...[client #1] pushed past staff into the road way."</p>	W000164	<p>W 164 Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Cardinal Services is committed to providing professional program services, appropriate active treatment and individualized programming to meet the needs of each client. The agency implemented protocol in the form of a monthly "Quality Assessment Analysis" to identify patterns of behaviors and/or injury in need of intervention (see attachment F). This protocol ensures the monthly review and analysis of all incidents, the establishment of action plans and will be monitored through monthly review for timeliness and efficacy. The agency established a contract with an outside behavioral consulting firm (see attachment C) to ensure timely receipt of professional program services necessary to train staff and implement active treatment plans as identified in the client's plan and/or through the identification of patterns via the monthly Quality Assessment Analysis. Client #1 and client #7 have been evaluated by the contracted Behavior Consultant</p>	11/09/2013	

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	<p>The report indicated client #1 was placed into a Cardinal Services support hold as outlined in [client #7's] HRC (Human Right's Committee) approved Self Management Plan (SMP) for his safety." Client #1 indicated he wanted to go to a mental health facility. The report indicated the incident would be discussed with client #1's psychiatrist.</p> <p>b.) A BDDS report dated 10/4/12 indicated client #1 attempted to push past staff towards the street two times after "becoming increasingly agitated." Client #1 was placed in a Cardinal Services Support hold twice. The report indicated client #1 "does not adapt to changes in his environment well. There are many changes taking place in [client #1's] home currently and he has new house mates and staff. The IDT (interdisciplinary team) believes that this is adding to [client #1's] anxiety and why his behavior is escalating."</p> <p>c.) A BDDS report dated 10/5/12 client #1 was restrained three times as a result of physically aggressive behavior and self injurious behavior. The report indicated staff "would continue to provided (sic) structure and routine to [client #1's] schedule and attempt to keep him focused on day to day activities to prevent this type of behavior in the future," and "staff</p>		<p>and subsequent interventions will be implemented by November 9, 2013. Ongoing monitoring and identification of the need for Professional Program Services will be conducted on a monthly basis by the Coordinators, Directors and Nurses. Coordinators and Directors Responsible.</p>				

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	<p>will continue to follow [client #1's] SMP and provide supports to him. Staff will report further concerns to the Residential Manager and the QDP (Qualified Disabilities Professional).</p> <p>d.) A BDDS report dated 11/21/12 indicated client #1 was placed in a physical hold twice after becoming physically aggressive. "Staff will follow [client #1's] plans and report all concerns to the Residential Manager and QDP."</p> <p>e.) A BDDS report dated 11/28/12 indicated client #1 was physically restrained twice after becoming physically aggressive. "Staff will continue to follow [client #1's] SMP and provide supports to him. Staff will report further concerns to the Residential Manager and QDP."</p> <p>f.) A BDDS report dated 12/5/12 indicated client #1 was physically restrained twice after becoming physically aggressive and attempting to go toward the road. "[Client #1] has shown an increase in physical aggression as well as attempts to go AWOL; this has been addressed with [client #1's] psychiatrist. He was seen by [Dr.] on Monday, 12/3/12 and changes were made to his psychiatric medications. [Client #1] has a follow up appointment scheduled with [Dr.] on 12/21/12 to discuss [client #1's] progress</p>				

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	<p>and reevaluate. Staff will continue to follow [client #1's] SMP and provide supports to him. Staff will report further concerns to the Residential Manager and the QDP. The QDP will be in contact with [client #1's] psychiatrist, [Dr.], if problems persist or worsen."</p> <p>g.) A BDDS report dated 3/11/13 indicated client #1 was physically restrained twice after becoming physically aggressive towards a peer. "Staff will continue to follow [client #1's] SMP and provide supports to him. Staff will report further concerns to the Residential Manager and the QDP."</p> <p>h.) A BDDS report dated 4/9/13 indicated client #1 was physically restrained after becoming physically aggressive towards a peer. "Staff will continue to provide supports to [client #1] and report any further concerns to the Residential Manager and the QDP immediately. Get with [QDP] to see if he had a recent med (medication) change at his pysch (psychiatrist) appointment and when his next appointment is."</p> <p>i.) A BDDS report dated 5/20/13 indicated client #1 was physically restrained after becoming physically aggressive. "Staff will continue to provide supports to [client #1] and report further</p>				

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	<p>concerns to the Residential Manager and the QDP immediately. [Client #1] has been counseled on street safety and finding more effective ways to express his needs."</p> <p>j.) A BDDS report dated 6/19/13 indicated client #1 was placed in a physical hold after being physically aggressive. "Staff will continue to provide supports to [client #1] and report any further concerns to the Residential Manager and the QDP immediately."</p> <p>Client #1's record was reviewed on 10/9/13 at 11:55 AM. A Self Management Plan dated July, 2013 indicated target behaviors of physical aggression, hallucinations, self injurious behavior, elopement (AWOL) (away without leave), obsessiveness. There was no evidence in the plan or in client #1's record of involvement of a behavioral specialist. Psychiatric visits on 10/1/12 indicated increases in client #1's Depakote from 500 mg (milligram) to 750 mg daily, his Zyprexa increased on 12/4/12 from 12.5 mg daily to 17.5 mg daily and clonidine increased from .05 mg daily to .01 mg daily on 3/5/13.</p> <p>2. The facility's accident and incident reports from March, 2013 to October, 2013 were reviewed on 10/2/13 at 2:40</p>				

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	<p>PM and indicated the following:</p> <p>a.) On 4/21/13 at 2:00 PM, client #4 was standing in the kitchen and client #7 "grabs his collar leaving a scratch (size and location not indicated)." Steps to prevent similar accidents in the future indicated "Nails looked trimmed so I don't know how this could have been prevented."</p> <p>b.) On 4/21/13 at 5:30 PM, client #5 was moving chairs to sweep and client #7 "came up behind him and grabbed his collar leaving a 1/2 inch scratch." Steps to prevent similar accidents in the future indicated "I don't know how this could have been prevented, his nails looked very short already."</p> <p>c.) On 4/22/13 at 5:30 PM, "as [client #2] walking (sic) down the hallway, [client #7] grabbed his shirt and scraping (sic) his nails against his skin causing 1 inch sized scratch near his left shoulder. Steps to prevent similar accidents in the future indicated "Try to prevent [client #7] from grabbing the shirts of his peers."</p> <p>d.) On 4/22/13 at 2:45 PM client #6 "was sitting in the living room sleeping [client #7] came in to the room and grabbed his shirt collar resulting in scratches." Steps to prevent similar accidents in the future</p>			

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	<p>indicated "Keep better idea where [client #7] is so this doesn't happen."</p> <p>e.) On 5/5/13 at 8:15 PM, client #5 "was waiting for meds (medications) when a peer (unidentified) reached up and grabbed his collar resulting in 3 scratch marks in the middle of his back." The report indicated the clients' self management plans were implemented, the accident was preventable. In a section titled "What could have been done differently to prevent it from happening?", the report indicated "Very hard to prevent unless the peer is within arm's reach of staff at all times."</p> <p>f.) On 5/25/13 at 6:30 PM client #6 was sitting in the living room "waiting for 8:30 PM meds. [Client #7] walked in sat next to [client #6's] chair and grabbed his left leg. Staff got him to let go and he immediately grabbed [client #6's] right forearm. (sic) Leaving pinch marks on [client #6's] leg and scratch marks on his arm." Steps to prevent similar accidents in the future indicated "Not have so many new subs (substitute contracted staff) in and out of the house in one day."</p> <p>g.) On 5/26/13 at 6:00 PM, client #5 "was in the dining room assisting with laundry. [Client #7] came up behind him and grabbed the back of his shirt, leaving</p>			

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	<p>scratch marks on the back of his neck area." Steps to prevent similar accidents in the future indicated "Not have so many subs in and out of the house in one day."</p> <p>h.) On 6/2/13 at 2:15 PM client #4 was standing in the kitchen and client #7 "grabs his arm. Staff intervenes and notices [client #4] has a one inch scratch on his elbow." Steps to prevent similar accidents in the future indicated "Nails look trimmed so I don't know how this could have been prevented."</p> <p>i). On 6/11/13 at 6:50 PM, "As staff were redirecting [client #7], he reached out and caught [client #2's] arm and left three 1 inch scratches on the bend of [client #2's] arm." Steps to prevent similar accidents in the future indicated "Nails looked trimmed, do not know how it could have been prevented."</p> <p>j.) On 6/13/13 at 6:45 PM "[Client #4] was coming into the kitchen when one of his peers (unidentified) grabbed his left arm, leaving behind 2 scratch marks." Steps to prevent similar accidents in the future indicated "to try and trim the guys nails and to file them as much as we can."</p> <p>k). On 6/21/13 at 7:50 PM, "Staff was giving meds to a peer when they heard [client #5] yell. They opened the door and</p>						

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	<p>found that [client #7] had grabbed his shirt. When staff undid [client #7's] fingers from the shirt they noticed 3 long scratches. Staff washed them with soap and water." Steps to prevent similar accidents in the future indicated "Staff filed [client #7's] nails to see if that could help. [Client #7] is looking for someone to be totally 1 on 1 with him."</p> <p>l.) On 6/30/13 at 6:00 PM, client #3 was sitting relaxing when a peer (unidentified) came up and grabbed [client #3's] shirt while scratching his right shoulder/neck area." Steps to prevent similar accidents in the future indicated "There is no way to prevent because it was an unprovoked attack."</p> <p>m.) On 7/3/13 at 7:00 PM, staff was cleaning the kitchen after dinner and a peer (unidentified) came up and grab (sic) the collar of [client #4's] shirt while staff had her back turned. The peer (unidentified) had one scratch mark along the back of his neck. Steps to prevent similar accidents in the future indicated "Staff needs to be made aware of named peer is entering a room where other peers are present."</p> <p>n.) On 7/6/13 at 4:45 PM, client #6 was sitting in the living room when he was grabbed by his peer (unidentified). As</p>						

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	<p>staff were removing his hand from [client #6's] arm a 1/2 inch scratch was left on his arm. Steps to prevent similar accidents in the future indicated "I don't (sic) know."</p> <p>o.) On 7/8/13 at 5:30 PM, client #6 "was in the kitchen waiting for dinner, and a peer (unidentified) came up and grabbed his arm leaving a scratch." Steps to prevent similar accidents in the future indicated "Staff needed to be made aware that the specific peer was entering the room."</p> <p>p.) On 7/20/13 at 4:00 PM, client #3 was observing dinner prep when his peer grabbed his collar before staff could get to him and (sic) scratched his neck (size not indicated). Steps to prevent similar accidents in the future indicated "His fingernails were short and filed in the morning. All other staff were busy at this time leaving one staff in the kitchen preparing dinner."</p> <p>q.) On 8/31/13 at 6:30 PM, client #5 "was standing by staff when a peer came up behind him and grabbed his collar leaving 2 scratches." Steps to prevent similar accidents in the future indicated "Be more mindful of where peers are."</p> <p>The Adult Services Director was</p>			

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	<p>interviewed on 10/7/13 at 12:51 PM. She indicated there was no involvement with a behavioral specialist to address client #1 and client #7's behaviors as yet, but the facility had been in the process of obtaining the services of a behavioral specialist. She indicated the use of physical restraint was less restrictive than placing client #1 in a mental health facility. She indicated the facility had not been successful in reducing client #7's behaviors resulting in injury until he was placed within arm's length of staff supervision. When asked if client #7's plan included reducing the need for the extra supervision, she indicated the facility was awaiting the results of the evaluation of client #7 by the behavior clinician before revising his plan.</p> <p>9-3-3(a)</p>			

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W000247	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation and interview, the facility failed for 1 of 4 sampled clients (client #3) to ensure he was offered choice in approved menu items.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 10/2/13 from 5:18 PM until 6:25 PM. During the evening meal client #3 grabbed chicken from the adjacent plate of staff #17. The food was removed from client #3's possession and client #3 was not offered an alternative menu item, and his plate and utensils were taken from the table.</p> <p>Staff #9 was interviewed on 10/2/13 at 6:20 PM. She indicated client #3 was only to be offered a second portions of vegetables per the dietitian's orders, and stated, "but he wants meat."</p> <p>Client #3's record was reviewed on 10/9/13 at 2:25 PM. Client #3's nutritional assessment dated 7/9/12 indicated a low fat, low cholesterol diet and did not indicate he was to be restricted from second portions.</p>	W000247	<p>W247 The individual program plan must indicate opportunities for client choice and self-management. Per Client 3's nutritional assessment, he was not to be restricted from second portions of low fat or low cholesterol food items. Staff received additional training on offering appropriate menu items for seconds as well as all person served dining plans on 11/1/13 (See attachment G.) To ensure that each person receiving supports through Cardinal Services is offered opportunities for choice and self-management and the freedom to have second portions when health and safety is not a concern, all staff will receive additional training outlining guidelines and appropriate options for healthy second portions by November 9, 2013. (see attachment H) Cardinal will ensure ongoing compliance through observations and documentation done by residential managers, coordinators, QDPs and support personnel. Observations are done daily by the shift manager, weekly by the residential manager, monthly by the QDP, and quarterly by the coordinator. (See attachment I) Coordinator, Manager and QDPs Responsible</p>	11/09/2013

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	The group home nurse was interviewed on 10/9/13 at 3:40 PM and stated clients should be offered seconds if they "insist" on additional portions. 9-3-4(a)			
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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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 interview for 2 of 4 sampled clients (clients #3 and #4), the facility failed to implement their Individual Support Plan (ISP) objectives as written.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 10/2/13 from 5:15 PM until 6:25 PM. Client #4 stood in the kitchen watching staff prepare food, and client #3 stood or sat on a chair in the dining room while staff prepared food for the evening meal. Staff carried food to the table for the evening meal. Client #4 was not prompted to carry food to the table and client #3 was not prompted to sign eat.</p> <p>Client #3's record was reviewed on 10/9/13 at 2:25 PM. Client #3's ISP dated 5/3/13 indicated an objective to "sign eat."</p> <p>Client #4's record was reviewed on</p>	W000249	<p>W249 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 s identified in the individual program plan. Cardinal Services, Inc. is committed to providing programming that encourages the greatest level of independence possible for those that we serve. To assure that this standard will be met, staff in the West Winona group home received training stating that staff must ensure goals are being ran as written to ensure objectives are met and that staff must encourage each person they support to participate in all daily living skills at every opportunity on November 1, 2013. (see attachment J) To ensure consistency throughout Cardinal Services, all Direct Support Professionals will receive training stating that goals should be run at every training</p>	11/09/2013

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	<p>10/9/13 at 1:40 AM. Client #4's ISP dated 9/13/13 indicated an objective to take food to table.</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 10/9/13 at 3:30 PM and indicated clients #3 and #4's objectives should have been implemented.</p> <p>9-3-4(a)</p>		<p>opportunity in a natural setting and that staff should document the progress of each goal as outlined by the QDP by November 9, 2013. (see attachment K) In addition, to ensure consistent management oversight, Residential Managers received training on November 4, 2013 outlining their responsibility for ensuring those they supervise comply with all active treatment and training responsibilities. (see Attachment L)</p> <p>Observation frequency will be increased to 3 times weekly until staff demonstrate competence in implementing continuous active treatment and the implementation of interventions per each individuals' program plan. Once competence is demonstrated, the regular observation schedule will resume. To ensure ongoing compliance, the Residential Manager, QDP and Residential Coordinator will monitor the staff performance through weekly, monthly and quarterly observations. QMRP, Residential Manager and Residential Coordinator Responsible</p>		

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based upon record review and interview for 3 of 4 sampled clients (client #1, #3 and #4), and 2 additional clients (clients #6 and #7), the facility failed to ensure medications were administered as indicated in physician's orders.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/2/13 at 2:40 PM and included the following:</p> <p>1. A BDDS report dated 12/3/12 indicated on 11/7/12 client #7 received the incorrect dose of Promethazine 25 mg (milligrams) for vomiting due to incorrect packaging. Client #7 did not have side effects and his physician indicated the dose he received was still within a "safe range." Staff were retrained on medication administration and would not be permitted to administer medication until able to demonstrate competency as observed by the nurse, or Residential Manager (RM). An attached investigation dated 12/4/12 indicated client #7's bubble package of pills had</p>	W000368	<p>W368 The system for drug administration must assure that all drugs are administered in compliance with all physician's orders. Cardinal Services takes our responsibility to provide for the safety of those we support seriously. To Ensure that medications are administered to people we support free from error West Winona staff received additional training outlining the proper procedures for error free medication passes and the addition of a medication pass check list by November 4, 2013. (see attachment M) To ensure consistency throughout Cardinal Services, all Direct Support Professionals will receive this training by November 9, 2013. The medication check list will be monitored daily for compliance and medication observations will be increased to 3 times per week until staff demonstrate competency. Once competency is demonstrated, the regular observation schedule will be resumed. To ensure this deficiency does not occur in the future, the Residential Manager, QDP, Nurse and Residential Coordinator will monitor the administration of medications through weekly, monthly and quarterly written observations.</p>	11/09/2013

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	<p>three 25 mg pills instead of one as ordered by the physician. The investigation indicated the Residential Manager took the pill pack to the pharmacy so that it could be repackaged properly.</p> <p>2. A BDDS report dated 2/18/13 indicated client #4 did not receive his 12 PM dose of Lorazepam (anti-anxiety). Client #4's physician was notified and indicated client #4 should be monitored for side effects. Staff was retrained and would not be permitted to pass medications until they are able to demonstrate competency prior to passing medications again.</p> <p>3. A BDDS report dated 3/7/13 indicated client #4 did not receive his Levothyroxine 50 mg (thyroid). Client #4 did not experience any side effects from the missed dosage. "Staff will be required to demonstrate competency while being observed by the Residential Manager, nurse, QDP or Residential Coordinator prior to being permitted to pass medications again."</p> <p>4. A BDDS report dated 4/3/13 indicated client #6 did not receive his 7 AM Fluoxetine HCL (hydrochloride) 20 mg capsule (depression), Jayln 0.5-0.4 mg capsule (prostate enlargement), Ferrous Sulf (sulfate) 325 mg tablet (iron</p>		Residential Manager, Nurse, QDP and Residential Coordinator Responsible.				

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	<p>supplement). The report indicated staff will receive disciplinary action and training regarding the medication omission.</p> <p>5. A BDDS report dated 5/22/13 indicated client #3 did not receive his Levetiracetam 500 mg (anti-convulsant) on 5/21/13. Staff had documented as given but staff failed to punch med (medication) out of his punch pack. Client #3 was monitored for side effects, staff were retrained and disciplinary action given for the missed medication.</p> <p>6. A BDDS report dated 5/27/13 indicated client #1 received 20 mg of Olanzapine (schizophrenia) on 5/25/13 instead of 10 mg. Staff will be disciplined according to facility policy and observed performing a medication pass to ensure accuracy. An attached investigation dated 5/28/13 indicated "For both medication passes staff admitted to not comparing the punch pack with the MARs (medication administration record)," and indicated staff was required to demonstrate competency in administering medications before administering medications again.</p> <p>7. A BDDS report dated 8/17/13 indicated client #3 did not receive his 7:00 AM dose of Tegretol (anti-convulsant) 200 mg the morning of August 16, 2013. Client</p>				

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	<p>#3 was monitored and staff was trained and disciplined.</p> <p>The group home nurse was interviewed on 10/9/13 at 3:40 PM. She indicated staff had been retrained on administering medications and a new medication checklist was now being implemented to reduce errors. She indicated medications should be administered without error.</p> <p>9-3-6(a)</p>			

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review, and interview for 2 of 4 sampled clients (clients #3 and #4), the facility failed to encourage, teach, and include clients in meal preparation.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 10/2/13 from 5:15 PM until 6:25 PM. Client #4 stood in the kitchen watching staff prepare food, and client #3 stood or sat on a chair in the dining room while staff prepared food for the evening meal. Clients #3 and #4 were not prompted or encouraged to assist in the preparation of the food.</p> <p>Client #3's record was reviewed on 10/9/13 at 2:25 PM. Client #3's comprehensive functional assessment dated 5/3/13 indicated he was capable of assisting with meal preparation with staff assistance.</p> <p>Client #4's record was reviewed on 10/9/13 at 1:40 AM. Client #4's comprehensive functional assessment dated 9/13/13 indicated he was capable of</p>	W000488	<p>488 The facility must assure that each client eats in a manner consistent with his or her developmental level. Cardinal Services recognizes our responsibility to teach adult daily living skills to those we provide services for. Staff in the West Winona group home received training on November 1, 2013 stating that staff must ensure they are including the people they support in all aspects of their meal preparation (see attachment N). DSP's also received training stating that staff must ensure goals are being ran as written to ensure objectives are met and that staff must encourage each person they support to participate in all daily living skills at every opportunity on November 1, 2013. (see attachment J) To ensure consistency throughout Cardinal Services, all Direct Support Professionals will receive training stating that goals should be run at every training opportunity in a natural setting and that staff should document the progress of each goal as outlined by the QDP by November 9, 2013. (see attachment K) In addition, to ensure consistent management oversight, Residential Managers received training on November 4,</p>	11/09/2013

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1207 W WINONA AVE WARSAW, IN 46580		
(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>assisting with meal preparation with staff assistance.</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 10/9/13 at 3:30 PM and indicated clients #3 and #4 should be involved in meal preparation.</p> <p>9-3-8(a)</p>		<p>2013 outlining their responsibility for ensuring those they supervise comply with all active treatment and training responsibilities. (see Attachment L) Observation frequency will be increased to 3 times per week until staff demonstrate competency in implementing training with regard to eating and meal preparation. Once competency is demonstrated, the regular observation schedule will resume. To ensure ongoing compliance, the Residential Manager, QDP and Residential Coordinator will monitor the staff performance through weekly, monthly and quarterly observations. QMRP, Residential Manager and Residential Coordinator Responsible</p>		